TABLE OF CONTENTS

Benefits by Design—General Provisions

The ***Benefits by Design*** group insurance program is a flexible benefits plan that allows you to design the benefits package that best meets your individual needs. ***Benefits by Design*** offers a wide range of benefits to choose from, including:

- Three medical plans
- Two dental plans
- Vision plan
- Health Care Flex Spending Account (FSA)
- Dependent Day Care Flex Spending Account (FSA)
- Employee and dependent life insurance
- Accidental death and dismemberment insurance (AD&D)
- Short-term disability insurance (STD)
- Long-term disability insurance (LTD).

Long-term care (nursing home) insurance may be purchased on an individual basis from John Hancock. Please contact the Benefits Office for information about this program.

The cost of your group insurance coverage depends on the plan you choose and the coverage classification you select (e.g., employee only, employee and family, etc.). This cost is shown on the individualized forms distributed by the Benefits Office each year during enrollment.

The company provides credits, or money, to help you pay the cost of your group insurance coverage. If you don't spend all of your credits for a certain type of coverage (e.g., life insurance), you may spend the remaining credits for other coverage or take the excess as additional taxable money in your paycheck. If you select group insurance coverage that costs more than your credits, you will generally pay the difference with **pre-tax** dollars from your paycheck. (Premiums for life, disability, and long-term care insurance are paid with after-tax dollars.)

Pre-tax contributions lower your taxable income so you don't pay state income tax, federal income tax, or Social Security tax on these amounts. Please note that lower Social Security taxes may result in slightly lower Social Security retirement benefits. Over the years, however, your tax savings from pre-tax ***Benefits by Design*** contributions should generally be greater than any

resulting Social Security benefit reduction. Please contact your tax advisor for additional information.

The ***Benefits by Design*** program is available only to regular full-time employees.

Benefits by Design Eligibility and Enrollment

Eligibility. The eligibility requirements for employees and dependents are described below.

Employees. If you are employed on a regular full-time basis, you are eligible to participate in ***Benefits by Design*** on the first day of the month following your date of full-time employment.

Dependents. For those plans that allow coverage for dependents, your eligible dependents are eligible to participate when you are eligible to participate.

Eligible dependents for the medical, dental, vision, and accident plans include:

- Your lawful spouse.
- Your unmarried natural or legally adopted children aged 18 and younger who are principally dependent on you for support. To be eligible for coverage under the medical, dental and vision plans, your dependent must not be eligible for benefits **as an employee** under any other group health plan.
- Your unmarried natural or legally adopted children ages 19 through 24, if they are full-time students and are principally dependent on you for support. To be eligible for coverage under the medical, dental, and vision plans, your dependent must not be eligible for benefits **as an employee** under any other group health plan.
- Your unmarried natural or legally adopted children ages 19 through 24, who are not students but who:
  - Are principally dependent on you for support
  - Maintain a legal residence with you, and
  - Are not on active duty in the armed forces of any country.

  To be eligible for coverage under the medical, dental, and vision plans, your dependent must not be eligible for coverage **as an employee** under any other group health plan.
- An unmarried child related to you by blood or marriage for whom you have assumed legal guardianship that is presumed to be permanent, if the child:
  - Normally resides in your household in a parent child relationship

– Is principally dependent on you for support and maintenance, and

– Otherwise satisfies the requirements described above for eligible dependents.

- Your unmarried natural or legally adopted dependent children age 25 or older who were covered under the plan on their 25th birthday and also were fully handicapped on their 25th birthday.

  Your child is fully handicapped if both of the following conditions are satisfied:

  - He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age (described above) for dependent children

  - He or she depends chiefly on you for support and maintenance.

  Proof that your child is fully handicapped must be submitted to Aetna no later than 30 days after the date your child's coverage would normally end.

  Coverage under any and all plans will cease on the last day of the month in which one of the following events occurs:

  - Cessation of the handicap

  - Failure to give proof that the handicap continues

  - Failure to have any required examination

  - Termination of your dependent child's coverage for any reason other than reaching the maximum age (such as marriage, obtaining medical coverage as an employee, etc.).

  Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to have your child examined as often as needed while the handicap continues at its own expense. An examination will not be required before 2 years from the date your child reaches the maximum age, and not more frequently than once each year thereafter.

- Subject to normal plan rules regarding dependent age, support, military service, and eligibility for other medical coverage, a natural child for whom there is a court-ordered divorce decree or Qualified Medical Child Support Order requiring you to provide coverage (to the age set forth in the decree or Order), regardless of whether the child resides in your home. Covered expenses will be considered in accordance with normal plan provisions.

Refer to the Life Insurance section for special rules regarding eligible dependents for the Dependent Life Insurance Plan.

No person may be eligible for benefits both as an employee and as a dependent. If you and your spouse are both employed by BBWI, one of you may choose to be covered as a dependent. Additionally, only one of you may cover your dependent children. If neither you nor your spouse are covered under the plans, your dependent children cannot be covered. **Employees are expected to observe these rules. Enrollment in double coverage is not valid, and benefits will not be paid even though contributions are collected. Premiums for double coverage will be refunded only if administratively feasible.**

Enrollment.

Initial Enrollment at Full-Time Employment. To enroll in ***Benefits by Design***, you must complete an enrollment form as soon as possible following your full-time employment and return it to the Benefits Office.

No medical examination is required for initial enrollment into the medical, dental, vision, Flexible Spending Account, AD&D, short-term disability (STD), long-term disability (LTD), life insurance (not in excess of certain limits), and/or long-term care plans, if you enroll for coverage within 30 days following the date you become eligible for coverage (first day of the month following your date of full-time employment). Please note, though, that evidence of good health will be required for the highest level of employee life insurance (5.25 × your base salary) and the highest level of dependent spouse life insurance (3 × your base salary).

Late Enrollment. If you do not enroll within 30 days after you first become eligible for coverage, you will not be able to enroll for coverage until a later date, generally during the next annual enrollment. When you enroll at a later date (after the initial 30-day period), you will be able to enter medical Plan C, but not plans A or B. Additionally, you will be required to submit at your own expense satisfactory evidence of good health for each person to be covered under the life, STD, LTD, and long-term care plans.

When Coverage Begins

Employees. Your initial coverage under the ***Benefits by Design*** group insurance plans is effective on the first day of the month following your date of employment (your eligibility date) if you complete and return your enrollment form to the Benefits Office before that date. If the Benefits Office receives your enrollment form within 30 days after your eligibility date, your coverage begins on the first day of the month after your enrollment form is received.

If the Benefits Office receives your enrollment form after the 30-day period specified above, you will not be able to enroll for coverage until a later date, generally during the next annual enrollment. As described above, evidence of good health is required for late enrollment into the life, short-term disability, long-term disability, and long-term care plans. Where evidence of

good health is required, your coverage will be subject to the review and approval of the insurance company administrator/provider. In this situation your coverage will be delayed until the first day of the month after the month in which the Benefits Office is notified that the insurance company has approved your application and any required evidence of good health.

Except in the case of medical plan coverage, you must be actively at work full-time on the effective date of your initial coverage. Otherwise, your coverage will become effective on the day you begin or return to work full-time.

Dependents. Your eligible dependents may be covered on the same date your coverage becomes effective, provided you make proper application.

Qualified Family Status Change. You may be able to add or drop dependents to your coverage under certain plans if you experience a qualified family status change (as described under "Changing Your Choices" in this Employee Handbook) and such change in coverage is consistent with the qualified family status change.

To provide coverage for a new eligible dependent, you must notify the Benefits Office in writing within 30 days from the date the person becomes a dependent (60 days if you are adding a new baby under your medical coverage—please note that this extended period does not apply to any plans other than medical).

Coverage for your new dependent will not be effective until you complete and return the benefit forms necessary to change your coverage. If these forms are returned within 30 days of when the Benefits Office receives your written notification of the new dependent, the dependent will be added to your coverage without proof of good health on the first of the following month except as follows:

- Medical coverage for your newborn children will be retroactive to birth.
- Medical coverage for your newly adopted children will be retroactive to the date you assumed legal custody and responsibility for the child's support.

If your benefit change forms are <u>not</u> received within 30 days of when the Benefits Office receives written notification of your new dependent, you will not be able to add your dependent to your coverage until a later date, generally during the next annual enrollment. At that time, evidence of good health will be required to enroll your dependent for dependent life or long-term care insurance. Where evidence of good health is required, coverage will begin on the first day of the month after the insurance company approves the evidence of good health and the Benefits Office receives that approval. **Please note that this provision applies to all situations, including newborns.**

Annual Enrollment. During annual ***Benefits by Design*** enrollment you may add your eligible dependents under your medical, dental, vision, and accident coverage without evidence of good

health (subject to the normal limitations on adding dependents under the 2-year election rules for dental and vision coverage). This is true even though you may not have experienced a qualified family status change. You will be required to provide evidence of good health to add a dependent under the dependent life insurance plan, or to enroll a dependent in long-term care insurance.

Reinstatement of Dependent. If you choose to drop an **eligible** dependent from coverage under one of the ***Benefits by Design*** plans, he/she may generally be re-enrolled, if still eligible, only during annual enrollment.

Special Medical Plan Provisions. The following additional provisions relate to dependent coverage under the medical plan only:

- Medical coverage for your newborn children is effective on the date of birth if you notify your Benefits Office within 60 days following birth and complete the required paperwork as described above. Coverage for newborns includes coverage of injuries, illnesses, medically diagnosed congenital defects and birth abnormalities, and premature births, as well as nursery charges for baby care while confined in the hospital.

- If you opt out of ***Benefits by Design*** medical coverage because you have other coverage (for example, if you are covered under the plan of your spouse) and then lose that coverage during the plan year, you will have 30 days from the date your coverage ends to enroll in the ***Benefits by Design*** plan. You and your eligible dependents may enroll in Plan C, but not in Plan A or B.

  Similarly, if you have an eligible dependent who loses medical coverage during a plan year, that dependent may be enrolled under your coverage within the 30 day period following the termination of such other coverage. Coverage will be effective the first of the month following enrollment.

- If you opt out of medical coverage and then gain a new dependent, you will have a special 30 day period from the date you acquire the dependent to enroll you and all your eligible dependents into the ***Benefits by Design*** medical plan. If you have a new baby, for example, you will have 30 days from the baby's birth to enroll yourself, your spouse, and the baby. You will be able to enroll in Plan C, but not in Plan A or B.

- If you are covered under the ***Benefits by Design*** medical plan and have a new baby, you will have 60 days from the date of birth to enroll the baby in coverage. Please note that coverage for new babies is not automatic, even if you have elected family coverage. ***You must notify the Benefits Office in writing within 60 days in order for your new baby to be covered retroactive to the date of birth.***

- The eligibility requirements for adopted children have been expanded to include children for whom you have legal custody and support obligation in anticipation of adoption,

regardless of whether the adoption is final. You will have 60 days from the date of adoption or the date you assume legal custody and responsibility for the child's support (whichever is earlier) to add the child to your coverage.

Please note that all changes to your benefit coverage during the plan year must be worked directly with the Benefits Office. (You may not add a dependent, for instance, by notifying the insurance company.) You will need to provide written notification to the Benefits Office within the specified time period, and complete all required paperwork, before requested changes can be made to your benefit coverage.

Specific coverage eligibility information for other group insurance plans is included in the specific sections for those plans.

Changing Your Choices

Annual Enrollment. During October and/or November, the company holds an enrollment for the Plan Year beginning the following January. At that time, eligible employees who are actively at work (i.e., who are not on a leave of absence) may have the opportunity to change their ***Benefits by Design*** elections. Employees who are not actively at work during annual enrollment may make medical plan changes during annual enrollment, and other enrollment elections when they return to active employment (assuming the Benefits Office receives appropriate written notification within 30 days of the employee's return to active employment).

Qualified Family Status Change. The annual enrollment period is generally the **only** time you may change your benefit choices unless you have a **qualified family status change**. If you have a qualified change in family status that results in the gain or loss of other insurance coverage, you must notify the Benefits Office in writing within **30 days** of the change. (The only exception is in the case of a newborn infant, where the notification period for adding the baby to existing medical coverage is 60 days. Please note that this extended notification period for newborns will not be applied to allow changes to Flex Spending Account or Dependent Life Insurance elections.)

With a qualified change in family status, you may change your level of coverage (e.g., employee and family instead of employee and spouse). However, you may not make a change to your basic plan selection or insurance coverage amounts. (For instance, you may not change from Dental Plan A to Dental Plan B or from Opt Out to Medical Plan C.)

A qualified change in family status includes:

- Your marriage or divorce
- The birth or adoption of your child
- The death of your spouse or child

- The loss of coverage eligibility for a dependent
- A change in employment status for you or your spouse
- A significant change in health care coverage or cost for you or your spouse under your spouse's health care plan (unless your spouse works for BBWI)
- The finalization of a Qualified Medical Child Support Order.

Any changes you want to make to your *Benefits by Design* choices must be consistent with the family status change you experience.

Special rules regarding changes that may be made to your Flex Spending Account participation if you experience a qualified family status change are included in that section.

Coverage changes requested when you have a qualified family status change will not become effective until you complete and return any required benefit forms. If these forms are returned within 30 days of when the Benefits Office receives written notification of your qualified family status change, you will not be asked to provide evidence of good health and your coverage changes will be effective the first of the following month (except in the case of newborns, where medical coverage only will be retroactive to birth). If your benefit change forms are not returned within 30 days of when the Benefits Office receives written notification of your qualified family status change, you will not be able to change your coverage until a later date, generally during the next annual enrollment. At that time, you will be required to submit evidence of good health to enroll your dependent in dependent life or long-term care insurance. Where evidence of good health is required, the effective date of coverage will be delayed. In these situations, your coverage changes will not become effective until the first of the month after the Benefits Office receives notification from the insurance company that the evidence of good health has been approved. This is true for all situations, including the addition of newborn babies.

If You Do Not Enroll—Default Coverage

If you do not participate during the annual enrollment period, you will be provided default levels of coverage (coverage you will automatically receive for the following year). The default coverage for employees who do not actively enroll is communicated each year in the ***Benefits by Design*** brochure, as well as on your personalized ***Benefits by Design*** enrollment form.

Benefit Coverage During Leave of Absence

Benefit coverage available during Family Medical Leave, Inactive Employee Status, Administrative Leave of Absence, Military Leave of Absence, and Professional Leave of Absence is described in Section 1 of this Employee Handbook. Please note that individuals who are on an approved leave of absence during annual enrollment generally are not able to make changes to their benefit elections until they return to active status.

Medical Plan

Introduction

The ***Benefits by Design*** medical plan is designed to help you pay medical costs that result from serious or prolonged disabilities, and from ordinary injuries or illnesses.

The medical plan is a self–insured plan. This means that the company, not an insurance company, funds all medical claims from a budget set aside for this purpose. The claims administrator (Aetna in the case of general medical services, and CIGNA Behavioral Care in the case of mental health/chemical dependency treatment services) acts as claims fiduciary, and in this capacity has full discretionary authority to interpret the terms of the plan and to review, deny, and otherwise make final claim decisions.

Summary of Your Medical Benefits

Benefits by Design offers three medical plan choices–Plans A, B and C. (Employees who live in the Washington, DC area may also participate in the Kaiser Mid-Atlantic HMO. Information about the Kaiser HMO is available from the Benefits Office.) All three medical plans cover the same services. Additionally, for employees who live in the network area, all three plans incorporate a Preferred Provider Organization (PPO) for general medical care and the CIGNA Behavioral Care Program for mental health and chemical dependency care. (Employees who live outside the network area are not covered by the PPO for general medical services. These employees receive reimbursements for services that are covered under the plan using the in-network schedule of benefits subject to reasonable and customary allowances. Amounts that are charged in excess of reasonable and customary allowances are the responsibility of the employee.) You may not waive medical coverage unless you certify on your enrollment form that you have coverage through another plan.

The primary differences among the three medical plans are:

The percentage of salary you pay as an annual deductible

The percentage of covered expenses you pay after the deductible is met or if the deductible is waived

The maximum percentage of salary you pay in a year before the plan pays 100% of covered expenses

The cost and availability of the mail order prescription drug plan

The monthly cost of coverage.

With the ***Benefits by Design*** program you can change your medical plan election each plan year. However, you may not **increase** your level of medical coverage more than one step each plan year. (For example, you may not move from Plan C to Plan A.) If you have previously waived coverage, you may enter Plan C during annual enrollment, but you may not move directly into Plan A or Plan B.

Preferred Provider Organization for General Medical Services

BBWI is a member of the Southeast Idaho Employers Coalition (SIEC), a group of large employers from our area that has developed a managed health care program known as a Preferred Provider Organization (PPO). The current PPO, which is owned and operated by CCN-Premier, was introduced within all three of BBWI's medical plans effective January 1, 1998.

The PPO is a network of hospitals, physicians, and other medical providers that have agreed to offer their services to BBWI employees at discounted rates. The SIEC PPO network includes physicians and hospitals in Idaho and Utah. Specific information about Southeast Idaho network providers is included in the PPO Directory that is published and distributed on a periodic basis during the year. Information about network providers in other parts of Idaho and in Utah may be obtained by calling 208-542-2851 (Idaho Falls number) or by contacting the Benefits Office. Because the PPO network of providers is subject to change, the most current PPO provider information may be obtained only by calling CCN-Premier at 208-542-2851. ***It is your responsibility to ensure that the doctor you choose is a member of the PPO network. Please remember to ask if your provider is an SIEC network provider at the time of your visit before any services are performed.***

Because of the discounted fee arrangement, both you and the company realize lower health care costs when you obtain your medical services through contracted PPO providers. To encourage you to take advantage of the PPO where possible, the medical plan schedule of benefits is less generous when services are not obtained through a network provider.

In reviewing the schedule of medical benefits, please note that while the "out-of-network" schedule will generally be applied to all services that are not obtained through the PPO network, it is recognized that there will be some situations when you or your dependents may be required by circumstances to use a nonparticipating provider. Examples of these situations are:

When needed medical services are not available within the SIEC network (including Southeast Idaho, Boise, Idaho, and Utah providers).

When medical services are obtained by your covered dependent who resides outside of the network service area, as in the case of a child who attends college in another state. Also, when medical expenses are received by employees who reside outside the network service area.

When medical services are obtained because of an urgent illness or sudden medical condition that occurs when you are outside the network service area, as might occur during a vacation.

When medical services are obtained for the initial treatment of a critical emergency or life-threatening situation.

In these situations, reimbursement for services obtained through a nonparticipating provider will be made at the "in-network" schedule of benefits (subject to the normal plan rules regarding medical necessity, reasonable and customary limitations, etc.). These are the only situations when out-of-network services will be reimbursed at the in-network level of benefits. This is true even if you are referred out-of-network by an in-network provider.

General Medical Coverage Overview

The table that follows summarizes the medical plan benefit levels for in-network and out-of-network general medical services. Please note that this table is provided only as a brief overview of your benefits. Some covered services may be subject to additional limitations or application of reasonable and customary allowances as explained in the detailed information that follows. (For example, all out-of-network and out-of-area charges, as well as all charges for routine physicals and cancer screening exams, are subject to reasonable and customary limitations.)

	Plan A Network Use In/Out	**Plan B** Network Use In/Out	**Plan C** Network Use In/Out
General Medical Services			
Annual Deductible – active employees (% of salary)			
Per Person	.5%/.5%	.8%/.8%	1.6%/1.6%
Per Family of 2	1.0%/1.0%	1.6%/1.6%	3.2%/3.2%
Per Family of 3 or more	1.25%/1.25%	2.0%/2.0%	4.0%/4.0%
Annual Deductible – retirees			
Per Person	$200/$200	$300/$300	$600/$600
Per Family of 2	$400/$400	$600/$600	$1,200/$1,200
Per Family of 3 or more	$600/$600	$900/$900	$1,800/$1,800
Deductible Waived			
Routine Physical Office Visits	Yes/Yes	Yes/Yes	Yes/Yes
Cancer Screening Office Visits	Yes/Yes	Yes/Yes	Yes/Yes
Inpatient Hospital	Yes/No	Yes/No	No/No
Surgery	Yes/No	Yes/No	No/No
Accidental Injury—treatment for 90 days which begins within 48 hours of the accident	Yes/No	Yes/No	No/No
Hospice Care	Yes/No	Yes/No	No/No
% Plan Pays			
Routine Physical Office Visits (no deductible)	100%/100%	100%/100%	100%/100%
Cancer Screening Office Visits (no deductible)	100%/100%	100%/100%	100%/100%
Other Services (after deductible)	80%/60%	80%/60%	70%/50%
Max You Pay Before Plan Pays 100% – active employees (% of salary-does not include deductible)			
Per Person	3%/6%	5%/10%	10%/20%
Per Family	6%/12%	10%/20%	20%/40%
Max You Pay Before Plan Pays 100% – retirees (does not include deductible)			
Per Person	$1,000/$2,000	$1,500/$3,000	$3,000/$6,000
Per Family	$2,000/$4,000	$3,000/$6,000	$6,000/$12,000
Maximum Lifetime Benefit	$1,000,000	$1,000,000	$1,000,000
Mail Order Drug Copayment	$10	$15	N/A
Retail Drug Card Copayment	20%	20%	30%
Utilization Review	Required	Required	Required

The annual deductible and out-of-pocket limits are expressed as a percentage of annual base pay not in excess of $80,000 (determined annually in January).

Plan Deductibles for General Medical Services. The annual deductibles for an individual and family vary depending on your salary and the plan you choose. Most unreimbursed out-of-pocket medical expenses will apply to satisfy your deductible. Charges that do not apply to your deductible include:

Your copayment for prescription drugs purchased through the mail order prescription drug program and/or the retail drug card program

Your deductible and/or copayments for mental health and/or substance abuse treatment under the CIGNA Behavioral Health program

Charges in excess of R&C allowances

Charges in excess of the plan's maximum allowances for routine physical examinations

Charges for services that are not covered

Charges for services for which the deductible is waived

The $300 excluded amount for not complying with the preadmission review procedures (see "Cost Management Features").

When the family deductible limit is met in a calendar year, all individual deductibles will be considered to have been met for the remainder of that calendar year.

Expenses applied to the individual or family deductible in the last three months of the calendar year (October, November, December) may also be applied to the deductible for the **next** calendar year. This helps you avoid paying deductible charges late in one year and having to start over again in the following year.

Amount the Plans Pay for General Medical Services. After you have reached the individual or family deductible amount for the plan you choose, the plan begins paying a percentage of the reasonable and customary (R&C) charges for medical services covered under the plan.

When the individual deductible is satisfied, the plan will pay a portion of that individual's covered medical expenses for the remainder of the calendar year. When the family deductible is satisfied, the plan will pay a portion of the covered medical expenses of all covered family members for the remainder of the calendar year. The percentage paid depends upon the plan you choose and whether you obtain your services through the PPO network. Except as specifically noted in this Employee Handbook, the percentage paid for in-network services is 80% for Plans A and B, and 70% for Plan C. Out-of-network services are reimbursed at only 60% for Plans A and B, and at only 50% for Plan C.

Please note that if you do not obtain your medical services from a PPO provider, you will be personally responsible for all amounts that exceed the plan's R&C limitations. This is generally not the case if you use the PPO network, since network providers are not allowed to bill you for excess R&C charges on most services. The only exceptions are for costs associated with physicals and cancer-screening exams. Reimbursement of these costs is subject to R&C limitations even though the services are received from a network provider.

Out-of-Pocket Maximum for General Medical Services. There is a limit (subject to R&C limitations) on how much you will be required to pay each year for covered medical expenses. Generally, after you have paid a certain amount for covered medical expenses for one person during the year, the medical plan will pay 100% (subject to R&C limitations) of the remaining covered medical expenses for that person for the rest of the year. Similarly, after you have paid a certain amount for covered medical expenses for your family, the plan will pay 100% (subject to R&C limitations) of the remaining covered medical expenses for all covered family members for the rest of the calendar year.

The maximum amount you pay each year is calculated as a percentage of your annual base pay not in excess of $80,000. The percentage used depends upon the plan you choose and whether you obtain your services through the PPO network. For all three medical plans, the out-of-pocket maximum is twice as much for out-of-network services as for in-network services.

The following rules are used in allocating costs to your in-network and out-of-network out-of-pocket maximums:

In-network expenses reduce both in-network and out-of-network out-of-pocket maximums

Out-of-network expenses reduce only the out-of-network out-of-pocket maximum

The total of both the in-network and out-of-network out-of-pocket maximums cannot exceed the out-of-network maximum.

Charges that do **not** apply to either the in-network or the out-of-network out-of-pocket maximum include:

Your copayment for prescription drugs purchased through the mail order or retail drug programs

Your copayment for mental health and/or substance abuse treatment under the CIGNA Behavioral Health program

The $300 excluded amount for not complying with the preadmission review procedures (see "Cost Management Features")

Charges greater than the R&C amount

Charges in excess of the plan's maximum allowances for routine physical examinations

Charges for services that are not covered under the plan

Amounts applied to the deductible.

Expenses applied to the individual or family out-of-pocket maximum in the last three months of the calendar year (October, November, December) may also be applied to the out-of-pocket maximum for the **next** calendar year.

Maximum Lifetime Benefit. The maximum lifetime benefit for all medical services (including mental health and chemical dependency services) is $1 million per covered person.

Covered General Medical Services

The plan pays the prescribed portion of R&C charges for the following covered general medical expenses incurred by you or your dependents while covered under the plan. To be covered under the plan, the services and supplies must be prescribed by a physician legally licensed to practice medicine and surgery, for the treatment of injuries and illnesses that are not work-related (e.g., not covered by Worker's Compensation). Also, except for elective routine physical examinations and cancer-screening exams, the medical services/supplies must be medically necessary as defined in the plan (see "Definitions"). To be eligible for reimbursement, claims for covered expenses must be filed within 12 months of the date of service.

Routine Physical Examinations.

You and your covered dependents will receive 100% reimbursement of reasonable and customary expenses (not subject to plan deductibles) for routine physical examinations, not to exceed specified age-related frequency schedules and benefit levels as described in the table below. Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Related laboratory and x-ray services will be reimbursed at 80% of reasonable and customary (70% for Plan C), up to a maximum of $200 per exam (not subject to plan deductibles). Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Amounts charged that exceed the maximum allowable benefit of $200 are the responsibility of the employee.

The frequency schedule and benefit levels applicable for routine physical examinations are as follows:

Age	Maximum Amount Payable

Age	Maximum Amount Payable
Newborn to age 2	$200 every calendar year* (multiple exams)
Age 2 to age 18	$100 every calendar year* (one exam)
Age 18 to age 35	$200 every three calendar* years (one exam)
Age 35 to age 50	$200 every two calendar* years (one exam)
Age 50 and over	$200 every calendar year* (one exam)
Plus related laboratory and x-ray services	$200 maximum each exam ($200 every calendar year* in the case of newborn to age 2)

* Calendar year refers to the 12-month period between January 1 and December 31.

A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

For your dependent child:

The physical exam must include at least the following services:

- A review and written record of the patient's complete medical history
- A check of all body systems
- A review and discussion of the exam results with the patient or with the parent or guardian.

A physical exam may also include the materials for and the administration of immunizations for infectious disease (including flu shots) and testing for tuberculosis. (However, a routine physical exam does not include a physician's office visit solely in conjunction with immunizations or testing for tuberculosis. Also, if a person has to make more than one visit to have a series of immunizations, the immunizations will be covered but a physician's office visit fee in connection with the immunizations will not be covered.)

A routine physical exam does not include:

Services which are covered to any extent under any other group plan of your Employer

Services which are for diagnosis or treatment of a suspected or identified injury or disease

Exams given while the person is confined in a hospital or other facility for medical care

Services which are not given by a physician or under his or her direct supervision

Medicines, drugs, appliances, equipment, or supplies

Psychiatric, psychological, personality or emotional testing or exams

Exams in any way related to employment

Premarital exams

Vision, hearing or dental exams.

Newborn Well-Baby Care. In addition to the above, coverage is provided for the initial physical exam performed in the hospital by the pediatrician to determine the health of newborns. This service is not subject to plan deductibles. In-network/out-of-network copayments do apply.

Cancer Screening Tests. There are certain tests used in the early detection of cancer which are covered under the medical plan. The plan provides coverage for Prostate Specificity Antigen (PSA) blood tests for men and routine mammograms and standard PAP tests for women. (Please note that the benefit paid for more expensive PAP tests such as Papnet, AutoPap, and Thin Prep will be limited to the benefit allowed for the standard PAP smear test.) Coverage for these procedures includes a standard PAP smear each calendar year for women age 18 and over, one baseline mammogram for women between the ages of 35 and 39, and one routine mammogram or PSA test per calendar year for individuals aged 40 and over.

Charges for cancer screening office visits are paid at 100% of R&C rates, not subject to plan deductibles. Charges for covered tests are covered at 80% of reasonable and customary (70% for Plan C), and also are not subject to plan deductibles. Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Inpatient Hospital Expenses. The plans pay a percentage of hospital charges for room, board, services, and supplies incurred during a period of hospital confinement. The covered expense for room and board charges is based on the hospital's most common room rate.

To be eligible for benefits, the hospital confinement must be prescribed by a physician legally licensed to practice medicine and surgery, and be medically necessary as defined by the plan (see "Definitions" and "Cost Management Features" to ensure maximum benefits).

Inpatient hospital charges are not subject to plan deductibles if the services are provided by a PPO network hospital. Charges for out-of-network hospitalizations are subject to normal plan deductibles, and are reimbursed at the lower out-of-network level of benefits subject to R&C allowances.

Smoking Cessation. Coverage is provided for smoking cessation, limited to two 90-day treatment periods. This 180–day treatment period is the maximum lifetime benefit allowed under the medical plan.

R&C charges for (1) the initial office visit for smoking cessation treatment and (2) doctor recommended smoking cessation products are included in this coverage. These charges are not subject to plan deductibles if the services/products are obtained from PPO network providers. Charges for smoking cessation services and products that are not obtained through the PPO network are subject to normal plan deductibles. Regular in-network/out-of-network plan copayments apply to all charges.

X-ray and Laboratory Charges. R&C charges for x–ray and laboratory procedures that are prescribed by a physician (legally licensed to practice medicine and surgery) in connection with the treatment of a medical condition are covered, subject to plan deductibles and in-network/out-of-network copayments.

Surgery. The plans pay a percentage of R&C charges incurred for a surgical procedure and for necessary post-operative treatment related to the surgical procedure, including inpatient and/or outpatient facility charges. Charges for an assistant surgeon and anesthetist are covered when necessary. When two surgeries are performed under the same anesthetic, your benefit for the second and any subsequent procedures will be reduced. This means your total benefit for the surgeries will be less than the percentage of charges normally covered under the plan you choose.

For multiple surgeries or multiple surgeons in attendance during one operative session, or for services or supplies for which data is unavailable, the R&C charge will be determined (by Aetna) using the charges generally incurred for cases similar in nature and severity in the geographical area (region, state, etc.) where the services were actually performed.

Charges for in-network surgeries are not subject to plan deductibles. Charges for surgeries that are not obtained from PPO providers will be reimbursed using the out-of-network schedule of benefits and will be subject to plan deductibles.

Prescription Drugs. All coverage of prescription drugs is subject to the normal provisions of the medical plan as discussed in this Employee Handbook. For example, prescription drugs will only be covered if they are determined to be medically necessary. Additionally, no coverage is provided for (1) extemporaneously prepared combinations of raw chemicals or (2) combinations of federal legend drugs in a non-FDA approved dosage form.

Mail Order Rx Program. If you are covered under medical Plan A or B, you may choose to file for prescription benefits through the Eckerd Health Service (EHS) mail service program otherwise known as Express Pharmacy Services. The mail order program is not available under Plan C. Medications used on an ongoing basis which require a doctor's prescription and are currently covered under the medical plans may be filled using the mail order program.

The Express Pharmacy Services prescription drug program is designed for medications which are taken on an ongoing basis for the treatment of chronic or long-term conditions. Under Plan A, you can receive a 30- to 90-day supply of medication for a $10 copayment per prescription. Under Plan B, your copayment is $15. Your copayment is not reimbursable under the medical

plan, and does **not** apply to your $1,000,000 lifetime maximum medical plan benefit, your medical plan deductible, or your out-of-pocket maximum. However, your copayment may be reimbursed from your Health Care Flexible Spending Account according to the provisions of that plan.

If you choose to use the mail order prescription drug program, your prescriptions are filled through Express Pharmacy Services and delivered to your home, postage paid. (Overnight delivery is available at an additional charge to you.) Included are reorder instructions for future prescriptions and/or refills. Please allow 3 weeks for delivery.

Retail Drug Card Program. The retail prescription program is intended for medications used in the treatment of acute conditions, such as a short-term illness, infection, or injury. This is particularly true for participants in Plans A and B, who are also able to use the mail order program. All medical plan participants, including those in Plan C, may purchase up to a 30-day supply of medications through the retail drug card program.

The retail drug card program is administered by Eckerd Health Services (EHS), using an extensive national network of pharmacies. Information about participating pharmacies may be obtained by contacting EHS toll-free at 1-888-562-3784.

With the retail drug card program, prescription drugs purchased at local pharmacies are not subject to medical plan deductibles. If you use one of the participating network pharmacies, you won't have to pay the full cost of the prescription at the time of purchase (and then file a claim for reimbursement). Instead, you pay only 20% (Plans A and B) or 30% (Plan C) of the negotiated cost of your medication at the time of purchase. You don't need to file any claims, since all of the paperwork is handled by EHS.

If you don't go to a participating network pharmacy, you will pay the full price of your medicine at the time of purchase and then file a claim for reimbursement. All claims for prescription drugs purchased on or after January 1, 1999, should be mailed to:

Eckerd Health Services
P.O. Box 2860
Pittsburgh, PA 15230-2860

Claims for prescription drugs purchased before January 1, 1999, should be mailed to Aetna, P.O. Box 578850, Oklahoma City, OK 73157-8850.

Prescription drugs purchased from non-network pharmacies will be reimbursed by EHS at 80% (Plans A and B) or 70% (Plan C). Please be aware that if you purchase your medications at a non-network pharmacy (or from a network pharmacy but don't use your retail prescription card), your reimbursement will not be based on the price you paid. (This is true even if this plan pays as secondary coverage under the coordination of benefit provisions.) Instead, EHS will calculate your reimbursement using the discounted price you would have been charged by a network

pharmacy. Because of this, your reimbursement will usually be less than 80% or 70% of the amount you actually paid for your medication. To illustrate, assume that a particular medication costs $50 at a non-network pharmacy, but only $40 at a network pharmacy. If you purchase the medicine from the non-network pharmacy, your reimbursement will be $32 (80% of $40) for Plan A or B, or $28 (70% of $40) for Plan C.

Your 20% or 30% share of the cost for prescription drugs purchased through the retail drug card program is not eligible for additional reimbursement under the medical plan, and does not apply to your $1,000,000 lifetime maximum medical plan benefit, medical plan deductible, or out-of-pocket maximum. Your copayment may be reimbursed, however, from your Health Care Flexible Spending Account according to the provisions of that plan.

Prescriptions During Hospital Confinement. Medications and drugs that are prescribed by a physician and dispensed by a hospital during a period of emergency, outpatient, or inpatient hospital confinement will be covered in accordance with the normal provisions of the medical plan. Claims for reimbursement of charges for these prescribed medications should be submitted to Aetna (P.O. Box 578850, Oklahoma City, OK 73157-8850) for processing and will be paid at 80% (Plan A or B) or 70% (Plan C) of the amount charged, subject to plan deductibles where applicable. Please note that your share of the cost of these medications will apply to both your $1,000,000 lifetime maximum medical benefit and to your out-of-pocket maximum.

Reimbursement for covered prescription medications during hospital confinements will be made by Aetna using in-network schedule of benefits.

Extended Care Facility Expenses. The plans pay a percentage of covered expenses incurred in an extended care facility (see "Definitions"), up to 60 days per period of confinement, as long as you or your covered dependent are **transferred directly to the facility from a hospital** where you were confined for treatment of a disease or injury for at least 3 consecutive days.

Care at the extended care facility must be for the same disease or injury for which you were hospitalized and must be supervised by a physician.

Covered charges under this provision include:

Local ambulance charges between the hospital (in which care was initiated) and the extended care facility

Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the private room limit.

Use of special treatment rooms

X-ray and lab work

Physical, occupational or speech therapy

Oxygen and other gas therapy

Other medical services usually given by an extended care facility. This does not include private or special nursing, or physicians services.

Medical supplies.

This section does not cover charges made for treatment of:

Drug addiction

Chronic brain syndrome

Alcoholism

Senility

Mental retardation

Any other mental disorder

Charges for extended care facilities and services are subject to normal plan deductibles and in-network/out-of-network copayments. Reimbursement of expenses for services received from out-of-network providers will also be subject to R&C limitations.

Home Health Care Expenses. The plans pay a percentage of covered expenses for up to 100 visits in the home each calendar year. To receive benefits, the covered person must be under the care of a physician and the services must be provided by a home health agency (see "Definitions") or by others under arrangements made by the agency. The services must be part of a home health care treatment plan established and periodically reviewed by the physician.

One home health care visit will consist of (a) a visit for covered services that are part of a home health care plan, or (b) up to four consecutive hours of service by a home health aide.

If necessary because of equipment needs, home health care services may also be provided on an outpatient basis at a hospital, extended care facility, or rehabilitation center, as long as the services are arranged by a home health agency and would be included as a covered inpatient hospital service under Medicare.

Covered home health care expenses include:

Part-time or intermittent care by a R.N. or by a L.P.N. if a R.N. is not available

Part-time or intermittent home health aide services for patient care

Physical, occupational, and speech therapy

The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:

- Medical supplies
- Drugs and medicines prescribed by a physician
- Lab services provided by or for a home health care agency.

This section does not cover charges made for:

Services or supplies that are not a part of the home health care plan

Services of a person who usually lives with you or who is a member of your or your spouse's family

Services of a social worker

Transportation.

Charges for home health care services are subject to normal plan deductibles and in-network/out-of-network copayments. Reimbursement of expenses for services received from out-of-network providers will also be subject to R&C limitations.

Hospice Care. The plans pay a percentage of covered charges for hospice care (see "Definitions") services for you or a covered dependent who is terminally ill. "Terminally ill" means the patient has 6 months or less to live.

Charges for hospice care obtained from PPO network providers are not subject to plan deductibles. Charges for out-of-network hospice care are subject to normal plan deductibles, and are reimbursed at the lower out-of-network level of benefits subject to R&C limitations.

Hospice care services must be provided while the terminally ill person is covered under this plan and after a physician certifies that the person is terminally ill. The terminal illness must result from a nonoccupational medical condition.

Hospice care benefits will be provided for up to 6 months from the date a physician certifies that the person is terminally ill. Benefits may be provided for a longer period of time if necessary as certified by the attending physician.

Covered hospice services must be provided or arranged by a hospice, and must be provided under a written hospice care program established and periodically reviewed by the hospice's medical director and team.

Inpatient hospice care in a hospital is also covered, as long as the hospital facility is operated by a hospice or provides inpatient care arranged by a hospice. Benefits will not be paid if the hospital hospice care includes any period of custodial care.

Inpatient hospice care can include one period of respite care per month while the terminally ill person is receiving hospice care benefits. "Respite care" is 5 consecutive days (or less) of inpatient care provided by a hospital for a terminally ill person who is under a hospice care plan. The respite care must be provided on an intermittent, nonroutine and occasional basis, and must provide a break from caring for the terminally ill person for those persons who usually provide the hospice care.

If the covered terminally ill patient dies while receiving hospice benefits, bereavement counseling for the surviving members of the family will be covered at the normal plan percentage (up to a maximum benefit of $250). To be eligible for this coverage, family members must obtain counseling within 12 months after the person's death.

Covered hospice care expenses include:

Charges by a hospice facility, hospital, or extended care facility for room, board, supplies, and other services furnished to a person while a full-time inpatient for pain control and other acute/chronic symptom management. (This would not include any excess daily room and board charges resulting from a private room.)

Services and supplies furnished to a person while not confined as a full-time inpatient.

Charges made by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under the direction of a physician. These include: (1) assessment of the person's social, emotional, and medical needs, and the home/family situation, (2) identification of the community resources which are available to the person, and (3) assisting the person to obtain the resources necessary to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.

- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.

- Medical supplies.

- Drugs and medicines prescribed by a physician.

Charges made by the providers below, but only if (1) the provider is not an employee of a Hospice Care Agency, and (2) such Agency retains responsibility for the care of the person.

- A physician for consultant or case management services.

- A physical or occupational therapist.

- A Home Health Care Agency, for (1) physical and/or occupational therapy, (2) part-time or intermittent home health aide services for up to 8 hours in any one day, primarily to care for the person, (3) medical supplies, (4) drugs and medicines prescribed by a physician, and (5) psychological and dietary counseling.

This section does not provide coverage for:

Funeral arrangements.

Pastoral counseling.

Financial or legal counseling. This includes estate planning and the drafting of a will.

Homemaker or caretaker services. These are services which are not solely related to care of the person. These include sitter/companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house.

Other Covered Medical Expenses. After you have satisfied the annual deductible for the plan you choose, the following medical services and supplies incurred during the calendar year will be covered under the plans if (1) they are not determined to be experimental in nature, (2) they are medically necessary, (3) they have not been considered under any other provisions of the plan, and (4) they are not excluded by the terms of the plan. Coverage of these services will be subject to normal in-network/out-of-network copayments.

Charges made for diagnosis and treatment by a physician legally licensed to practice medicine and surgery, or who state law requires to be recognized as a physician for group insurance purposes. (Please note that chiropractors are not included.)

Charges made by a nurse practitioner, surgery technician, or surgery assistant.

To the extent not reimbursed by dental insurance, charges made by a qualified physician, dentist, or orthodontist for services and supplies involved in treating certain medical conditions of the mouth, jaws, jaw joints, or supporting tissues (including bones, muscles, and nerves). Included are:

- Hospital services and supplies received for an inpatient hospital confinement that is medically necessary because of the person's condition.

- Surgery needed to (1) treat a fracture, dislocation or wound, (2) cut out cysts, tumors, or other diseased tissues, or (3) alter the jaw, jaw joints, or bite relationship by a cutting procedure when appliance therapy alone cannot result in functional improvement. Not included are cutting procedures for extractions, alveolectomy, dental alveoplasty, and/or repair of the teeth and gum.

- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

- Treatment of accidental injuries to sound, natural teeth (does not include tooth breakage while chewing) or surrounding tissues sustained while covered under the plan. Included is dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition (1) natural teeth that were damaged, lost, or removed, or (2) other body tissues of the mouth that were fractured or cut due to injury. Any such teeth must have been either free from decay or in good repair, and firmly attached to the jaw bone, at the time of the injury. To be covered, the treatment must generally be done in the calendar year of the accident or the following calendar year.

  If crown/caps, dentures, bridgework, or in-mouth appliances are installed due to such injury, coverage will be provided only for the first crown needed to repair each damaged tooth, the first denture or fixed bridgework to replace lost teeth, and the in-mouth appliance used in the first course of orthodontic treatment after the injury.

- Orthodontic services in conjunction with orthognathic or craniofacial surgery to treat disease, injury, or severe congenital deformity. All expected services should be submitted to Aetna for a predetermination of benefits in order to verify that the anticipated services are a covered benefit.

Except as specifically provided above, no coverage is included under this section for:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain

- Root canal therapy

- Routine tooth removal
- Removal, repair, restoration, or repositioning of teeth lost or damaged in the course of biting or chewing
- Repair, replacement, or restoration of fillings, crowns, dentures, or bridgework
- Periodontal treatment
- Dental cleaning, in-mouth scaling, planing, or scraping
- Myofunctional therapy, including muscle training therapy and training to correct or control harmful habits.

Organ and tissue transplants. (See National Medical Excellence Program discussed later in this section.)

Certain charges made by a registered nurse, or a currently licensed practical nurse, provided:

- He or she is not a relative by blood or marriage
- He or she does not reside in your home
- The nursing care is necessary as evidenced by a written statement from the attending physician.

Covered charges under this section include charges made by a R.N., L.P.N., or a nursing agency for skilled nursing care. For this provision, skilled nursing care includes the following services:

- Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

The following services are <u>not</u> <u>included</u> as skilled nursing care:

- That part or all of any nursing care that does not require the education, training, and technical skills of a R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities.
- Any private duty nursing care given while the person is an inpatient in a hospital or other health care facility.

- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.

- Care provided solely for skilled observation, except for one 4-hour period for no more than 10 consecutive days following the occurrence of (1) a change in patient medications, (2) the treatment by a physician of an emergency condition, or the onset of symptoms indicating the probable need for such treatment, (3) surgery, or (4) release from inpatient confinement.

- Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Charges for emergency transportation within the continental United States and Canada for the first trip to and from a hospital by professional ambulance, by regularly scheduled airline, or by air ambulance to and from the nearest hospital qualified to provide special treatment for the injury or illness.

Sterilization and sterilization reversal.

Anesthetics and oxygen.

Chemotherapy and radiation treatment.

Most prescription drugs and medicines, including drugs prescribed for treatment of mental disorders and alcoholism/drug abuse. Drugs and medicines may not be covered if prescribed in conjunction with non-covered services. (See Prescription Drugs as discussed earlier in this section.)

Physician prescribed hormonal pellets.

Hospital outpatient expenses for diagnosis or treatment of an illness.

Rental fees (not including maintenance fees) up to the purchase price of durable medical equipment. This includes, but is not limited to, a hospital bed, a manual wheelchair, and equipment to administer oxygen. Your attending physician must provide documentation of medical necessity for the rental or purchase of the equipment (if purchase is more cost-effective). The cost of replacement and/or repair of equipment may be covered if it is cost-effective and medically necessary.

Blood and blood plasma to the extent charges are not reduced by blood donations.

Braces, crutches, and prostheses when medically necessary because of an injury or illness, including replacement charges when required because of a pathological change (but not repair, maintenance, or replacement due to wear), and colostomy supplies.

An initial wig or hairpiece when prescribed by a physician to replace hair loss due to disease, injury, or treatment of disease (e.g. alopecia, areata, alapecia totalis, alopecia universalis burns, chemotherapy, fungus, lupus, or radiation therapy).

Foot orthotics, if medically necessary and therapeutic, limited to either two left or two right, or to one pair (not multiple sets) per calendar year.

Support stockings, if medically necessary and if they are the type that require a physician's prescription.

Physiotherapy.

Speech therapy by a physician or legally licensed speech pathologist to restore or rehabilitate fully developed speech loss due to an illness, injury, or congenital defect if surgery has corrected the defect prior to the therapy.

Medically necessary mastectomies, and reconstructive surgery and prostheses following mastectomies. Covered members who receive benefits for a medically necessary mastectomy, and who elect breast reconstruction after the mastectomy, will receive coverage for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery on, and reconstruction of, the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in accordance with plan provisions, subject to the same annual deductibles and copayment provisions that apply for the mastectomy.

Hospital coverage for the mother and newborn child in connection with childbirth. Benefits for a hospital length of stay (in connection with childbirth) for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or to less than 96 hours following a delivery by cesarean section. Coverage will be provided for a shorter stay if the attending provider, after consultation with the mother, discharges the mother and/or newborn earlier than the minimum allowed hospital stay noted above. In this case, benefits will be payable for two post-delivery home visits by a health care provider.

Payment of benefits under this section is subject to normal plan rules regarding hospital precertification.

Costs for Coverage

Contributions for medical coverage are made on a pre-tax basis. The cost depends on the plan you choose and the coverage classification you select (employee only, employee and family, employee and children, or employee and spouse). The company provides credits to help you pay the cost of this coverage.

If you can be covered under another group plan and choose to opt out of the LMITCO Medical Plan, you may receive a cash credit of $50 as an addition to your monthly pay. (This does not apply if you are covered in the ***Benefits by Design*** Medical Plan as a dependent of your spouse.) The $50 cash credit is treated as additional wages subject to normal income tax withholding.

Cost Management Features

The features described below are designed to help you be a better health care consumer and to help the company better manage health care costs.

Hospital Self-Audit Incentive Program. The Hospital Self-Audit Incentive Program rewards employees who identify excess charges on their hospital bills, and complete the process described below, within 90 days of their discharge or date of service.

If you find errors of $100 or more in your hospital bill, send the corrected bill, a copy of the incorrect bill, and a Hospital Audit Refund Application (obtained at your Benefits Office) to the Aetna claims office. You may be eligible for a cash incentive, ranging from $25 to a maximum of $1000, representing 25% of the total overcharge.

Hospital Preadmission Review. The medical plan includes a hospital preadmission review program to help determine the duration and medical necessity of your proposed hospital stay.

If your physician recommends **inpatient hospitalization** for any reason, you or a family member (or your physician) should contact the Aetna Care Review Unit at least 7 days **before** you are to be hospitalized. In case of an emergency admission, you or a family member (or your physician) must contact the Care Review Unit within 2 business days following admission, **even if you have been discharged by that time**. When calling the Care Review Unit, please be prepared to provide the doctor's name and telephone number, and expected date of hospitalization.

The number to use in contacting the Care Review Unit is:

1-800-624-2000.

After the initial call, the Care Review Unit will contact your physician to discuss the proposed hospitalization and obtain more information. You, the attending physician, and the hospital will be notified of the results of this review. If you do not agree with the results, you or your physician may request reconsideration of the decision by contacting the Care Review Unit.

Although the medical plan will only pay for that portion of your hospital stay that is determined by the Care Review Unit to be medically necessary, **you** always make the final decision about your treatment.

Please remember that **you have the responsibility to make sure your doctor has provided the required information to the Care Review Unit** to certify your hospitalization. If you do not follow the preadmission review procedure, $300 will be deducted from the benefits payable for these covered services. Additionally, if your inpatient hospitalization is not considered by Aetna to be medically necessary, the resulting charges will generally not be paid by this plan.

Continued Stay Review. A Care Review Unit staff member will periodically review your hospitalization and length of stay with your physician. If your physician recommends an extended length of stay beyond what was originally approved during the preadmission review, the Care Review Unit staff member will determine the medical necessity of an extended stay. If there is sufficient medical evidence to warrant additional time in the hospital, the reviewer will approve an extended length of stay and your coverage for the hospitalization will continue.

If your extended stay is **not** approved, a physician advisor associated with the Care Review Unit will notify you and your physician. If you do not agree with the decision, you or your physician may request reconsideration of the decision by contacting the Care Review Unit. While the final decision about your treatment is made by you, please be aware that an extended hospitalization that is not approved by the Care Review Unit will generally not be paid by BBWI's medical plan.

Medical Case Management. If you or a covered dependent sustains a severe nonoccupational injury or illness (see "Definitions"), an Aetna medical case management consultant will review your situation to help ensure that you or your dependent receives medically necessary and appropriate treatment for the condition. Severe nonoccupational injuries and illnesses include, but are not limited to, major head traumas, spinal cord injuries, severe burns, severe strokes, organ transplant situations, and neonatal high risk conditions.

To determine the benefits available under the medical plan in these situations, the medical case management staff will review the patient's condition for the following:

Medical status

Current and future treatment plans

Long–term cost projections

Appropriateness and effectiveness of care.

The medical case management consultant may recommend alternate methods of treating your or your dependent's condition to ensure that the most appropriate and cost-effective care is received. These alternate treatment methods may include transferring the patient from a hospital

to an extended care facility, or arranging for in-home care. You, your family, and the attending physician will all be involved in any decisions regarding proper care.

In the administration of this section, the company may authorize the payment of claims which do not come within the specific benefit provisions of this plan if it determines that such payment is within the intent of the plan, or is in the best interest of the plan, but any such payments, although a valid charge against the plan, will not be considered to be a precedent in the disposition of other claims.

National Medical Excellence Program. In some situations, you or your dependents may be referred by Medical Case Management to Aetna's National Medical Excellence (NME) program.

The NME program coordinates all solid and bone marrow transplants and other specialized care that cannot be provided within a NME Patient's local geographic area. To be eligible for coverage under this section, a person must:

Require any of the listed procedures/treatments for which the charges are a covered medical expense.

Contact Aetna and be approved by Aetna as a NME patient, and

Agree to have the procedure/treatment performed in the hospital designated by Aetna as the most appropriate medical facility.

If a person is approved as a NME patient and care is directed to a medical facility more than 100 miles from the person's home, the plan will pay a benefit for travel and lodging expenses, but only to the extent described below.

Travel Expenses. These are expenses incurred by a NME patient for transportation between his/her home and the medical facility to receive services in connection with a listed procedure or treatment.

Also included are expenses incurred by no more than one companion for transportation when traveling with a NME patient between the NME patient's home and the medical facility to receive such services.

For purposes of this section, a companion is a person whose presence as companion or caregiver is necessary to enable a NME patient to (1) receive services in connection with any listed procedure/treatment, or (2) to travel to and from a designated medical facility.

Lodging Expenses. These are expenses, up to the lodging expense maximum per night, incurred by a NME patient for lodging away from home while traveling between his/her home and the medical facility to receive services in connection with any listed procedure or treatment.

Also included are expenses, incurred by no more than one companion for lodging away from home:

While traveling with a NME patient between the NME patient's home and the medical facility to receive services in connection with any listed procedure or treatment; or

When the companion's presence is required to enable a NME patient to receive such services from the medical facility on an inpatient or outpatient basis.

For the purpose of determining travel and lodging expenses, a hospital or other temporary residence from which a NME patient travels in order to begin a period of treatment at the medical facility or to which he or she travels after dismissal from the medical facility at the end of a period of treatment will be considered to be the NME patient's home.

Travel and Lodging Benefits Maximum. For all travel and lodging expenses incurred in connection with any one NME procedure or treatment:

The total benefit payable will not exceed the travel and lodging benefit maximum per episode of care, as determined by Aetna.

Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes a NME patient and ends on the earlier of (1) one year after the day the procedure is performed, or (2) the date the patient ceases to receive any services from the medical facility in connection with the procedure.

Benefits paid for travel and lodging expenses do not count against any person's lifetime maximum benefit.

Limitations. Travel and lodging expenses under this section do not include, and no benefits are payable for, any charges which are covered under any other part of this plan.

Predetermination for Surgical Benefits. If you want to know the surgical benefits under your plan before you agree to undergo a recommended surgical procedure, you should complete and file a PreSurgical Benefit Determination Form (available from the Benefits Office) with Aetna. Aetna will review your form and tell you and your physician how much of the surgery charges may be covered.

The predetermination of benefits is not intended to limit your choice of physicians or tell you or your physician what treatment and services should be performed. However, the predetermination does provide you and your physician with information on what is covered (subject to verification of medical necessity, etc.) and the benefit that may be payable. The predetermination does not represent a guarantee of benefits.

General Medical Expenses Not Covered

Expenses for services **not** covered under the plan include, but are not limited to, the following:

Hospitalization, treatment, services, supplies, or drugs that are not medically necessary as determined by Aetna.

Charges for mental health and substance abuse treatment. Coverage for these services is described below under "CIGNA Behavioral Health Program for Mental Health and Chemical Dependency Care."

Charges greater than the R&C amount as determined by Aetna.

Occupational accidents or illnesses for which benefits are payable under Worker's Compensation.

Eye examinations for diagnosis or treatment of astigmatism, myopia, hyperopia, or eye refractions; or the fitting or cost of eyeglasses or contact lenses.

Hospitalization, treatment, or services for radial keratotomy or any related surgery to correct vision.

Fitting or cost of hearing aids.

Plastic surgery, reconstructive surgery, cosmetic surgery, or other services or supplies (including hospital charges) which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. Exceptions are made to the extent these services are needed to:

- Improve the function of a body part (that is not a tooth) that is malformed (1) as the result of a severe birth defect (including harelip or webbed fingers/toes), or (2) as the direct result of a disease or surgery performed to treat a disease or injury.

- Repair an injury which occurs when the person is covered under the plan.

Hospitalization, examinations, or medical/surgical services and supplies that are determined by Aetna, CIGNA, or Eckerd's (as applicable) to be experimental or investigational.

A drug, device, procedure, or treatment will be determined to be experimental or investigational if:

- There is insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

– If required by the FDA, approval has not been granted for marketing.

– A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes.

– The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion may not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna, CIGNA, or Eckerd's (as applicable) determines that:

– The disease can be expected to cause death within one year, in the absence of effective treatment, and

– The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna, CIGNA, or Eckerds (as applicable) will take into account the results of a review by a panel of independent medical professionals selected by Aetna (or CIGNA/Eckerd's as appropriate). This panel will include professionals who treat the type of disease involved.

Also (if Aetna (or CIGNA/Eckerd's as appropriate) determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease), this exclusion will not apply with respect to drugs that:

– Have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or

– Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute.

Transplant and donor benefits for:

– Any transplant expense when an approved alternate remedy is available

– Any animal organ or mechanical equipment device or organs

– Any financial consideration to the donor other than for a covered expense which is incurred during the transplant procedure.

Hospitalization, examinations, or medical/surgical services and supplies which do not meet accepted standards of medical practice.

Services and supplies furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents, or medicaid.)

Any services, supplies, treatment, or hospitalization provided without the recommendation and approval of a licensed physician. Reimbursement of medical/surgical charges for services is limited to those services rendered by a physician licensed to practice medicine and surgery in the state in which the charge is incurred.

Chiropractic services.

Outpatient occupational therapy, except to restore functions lost as the result of an accident.

TMJ (temporomandibular joint syndrome) treatment, except diagnosis and surgery.

Vitamins, nutritional supplements, special diets, comfort or convenience services or supplies, nonprescription drugs, or prescriptions purchased under the company's mail order or retail Rx program.

Birth control pills and devices, except where medically necessary (as determined by Aetna and/or Eckerd's) to treat a documented medical condition.

Extemporaneously prepared combinations of raw chemicals, or combinations of federal legend drugs in a non-FDA approved dosage form.

Prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids; or other care, repair, removal, replacement, or treatment of teeth or surrounding tissues. The only exceptions are (a) treatment to sound natural teeth resulting from an accidental injury while covered under the plan (to the extent not covered under BBWI's dental insurance plan), (b) removal of a tumor or cyst in the mouth, or incision and drainage of an abscess or cyst, (c) any other oral surgery which doesn't involve any tooth structure, alveolar process, or gingival tissues, and (d) orthodontic services received as part of the staged treatment of serious medical conditions or congenital birth defects.

Transportation or travel charges, except as specified in the "Other Covered Medical Expenses" section.

Amniocentesis, ultrasound, or any other procedure used to determine the sex of a fetus, unless determined by Aetna to be medically necessary.

Any expense related to treatment for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, as determined by the insurance company, and present significant symptomatic medical problems), or any treatment of obesity (except surgery to treat morbid obesity), including dietary programs (except for laboratory charges in connection with monitoring the patient's medical condition).

Any expense that is incurred because of an injury or illness resulting from war or any act of war, whether declared or undeclared.

Treatment of a dependent child's newborn child, including complications.

Hospitalization, examinations, or medical/surgical treatments and supplies furnished before you or your dependents were covered under this plan, or related to a period of hospital confinement before you were covered under this plan.

Charges that would not have been incurred if coverage under this plan did not exist, or that you or your covered dependents are not obligated to pay (including expenses which are the responsibility of another coverage).

Infertility treatment and any expense to promote fertility, including, but not limited to, fertility tests and any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, embryo transfer, embryo reduction, or any similar treatment or method.

Any expense that is primarily for a person's education, training, or development of skills needed to cope with an injury or sickness.

Custodial care, developmental care, or domiciliary care as determined by Aetna, etc.

Any expense for sex transformations and any treatment related to sexual dysfunction that does not have a physiological or organic basis.

Speech therapy, except to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.

Charges for personal items such as television and telephone rentals while hospitalized.

Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.

Elective abortions, unless the life of the mother is in danger or severe complications arise (as determined by Aetna).

Orthopedic shoes or other supportive devices for the feet unless attached as an integral part of a brace.

Acupuncture or acupressure treatment except if services are rendered by a medical doctor and are determined to be medically necessary by Aetna.

Services, treatment, education testing, or training related to learning disabilities or developmental delays.

Care furnished mainly to provide a surrounding free from exposure that can worsen a person's disease or injury.

Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy.

Services of a resident physician or intern rendered in that capacity.

Marriage, family, child, career, social adjustment, pastoral, or financial counseling.

Filing Medical Claims

Aetna is the claims administrator for general medical expenses under all three medical plans.

Claims for general medical services should be mailed to Aetna at the following address:

Aetna
P.O. Box 578850
Oklahoma City, OK 73157-8850

Please note that most PPO providers will submit claims directly to Aetna on behalf of the patient. It is only if the PPO provider does not perform this service that employees will need to submit their claims to Aetna.

Claim forms for Aetna are available from the company reception desks in Idaho Falls offices, the site dispensaries, and the Benefits Office.

To avoid processing delays, please answer all questions when completing your claim form. As an employee, you are responsible for the accuracy of all data supplied on the claim form. Please be sure that all submitted bills include the following information:

Name and address of provider of service

Name, address, and company of employee

Social Security Number of employee

Name and birthdate of patient, and relationship of the patient to the employee

Medical diagnosis

Nature of services or supplies furnished

Date and amount of charges incurred, and indication of any payment made

BBWI's group number (701216).

Payments of Benefits. Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you advise Aetna otherwise by the time you file the claim.

Additionally, the plan may pay up to $1,000 of any benefit to any of your relatives whom it believes is fairly entitled to such payment. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Recovery of Overpayment. If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this plan has the right:

To require the return of the overpayment on request; or

To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this plan may have with respect to such overpayment.

Assignments. Coverage under this plan may not be assigned. Medical benefits under the plan may be assigned, but only with authorization by Aetna.

Physical Examinations. Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This may be done (at no cost to you) at any reasonable time while certification or a claim for benefits is pending or under review.

Legal Action. You must file your claims within 12 months of the date of service or charges for the service will **not** be considered eligible for processing under BBWI's plan.

Generally, no legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, unless the condition was excluded from coverage on the date of the loss.

Additional Provisions. The following provisions apply to your coverage.

You cannot receive multiple coverage under this plan because your spouse also works for BBWI. For example, if your spouse works for BBWI you are not allowed to carry coverage in your own name as a BBWI employee and also be carried as a dependent under your spouse's coverage.

In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this plan. Additional provisions are described elsewhere in the Plan Document on file with your employer. If you have any questions about the terms of this plan or about the proper payment of benefits, you may obtain more information from your employer, or you may call Aetna at 1-877-801-0825.

Your employer hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued as to all or any class of employees.

CIGNA Behavioral Health Program for Mental Health and Chemical Dependency Care

The benefits available under BBWI's medical plan for mental health and chemical dependency care are administered through the CIGNA Behavioral Health program. The CIGNA program is included within all three medical plans. You do not enroll for this program separately from your general medical coverage.

The CIGNA program includes a nation-wide network of quality providers and is designed to ensure that you receive appropriate mental health and substance abuse care. By providing personal case management for each treatment plan, and by continually monitoring each patient's progress, this program ensures that the treatment received is of high quality and consistent with individual patient needs.

Under the CIGNA program, all treatment must be preauthorized by CIGNA in order for you to receive any reimbursement for mental health or substance abuse services. Please remember to call the CIGNA assessment and referral line at 1-800-455-8187 before you begin any mental health and/or substance abuse treatment. This includes any treatment for conditions such as Attention Deficit Disorder (ADD) and medication management, even if these services are obtained from a medical doctor instead of from a mental health care provider, as well as procedures such as psychological testing and biofeedback.

You may contact CIGNA by telephone 24 hours a day, seven days a week. Your call will be answered by an intake specialist who will ask you some questions in order to direct you to an appropriate provider. CIGNA has a national network of providers that includes hospitals, outpatient facilities, psychiatrists, psychologists, and master's level therapists. These providers must meet strict professional and licensure requirements in order to be included in the CIGNA network. Because CIGNA licenses its own providers, the CIGNA network may not include the same providers as the network developed for the CCN-Premier network for general medical services. Please contact CIGNA to make certain that your provider is a member of the CIGNA network.

When your mental health/substance abuse services are preauthorized by CIGNA and you obtain your services from a CIGNA provider, the cost of your services will be reimbursed at the "in-network" schedule of benefits. If you obtain preauthorization of your treatment from CIGNA and choose to seek treatment from a licensed provider who is not a CIGNA participating provider, you will be eligible only for a lower "out-of-network" level of benefits (please see the schedule of benefits that is provided later in this section). ***If you do not preauthorize your care with CIGNA, no benefits will be payable for the services you obtain. This is true even if your provider is a member of the CIGNA network.***

In the event you have an emergency, CIGNA will direct you to the nearest emergency room. If you are unable to call CIGNA in an emergency and you or your dependent are admitted to the

hospital for inpatient care, you or your family member must notify CIGNA by 5:00 p.m. on the next business day. Failure to do so could result in lower benefits or denial of coverage.

Summary of Mental Health Coverage. The table below summarizes the mental health and chemical dependency benefits for in-network and out-of-network services under the CIGNA program:

	Plan A Network Use In/Out	**Plan B** Network Use In/Out	**Plan C** Network Use In/Out
Mental Health Services			
Annual Deductible-Per Person	NA/$200	NA/$300	NA/$600
% Plan Pays After Deductible	80%/60%	80%/60%	70%/50%
Max You Pay Each Calendar Year Before Plan Pays 100%	$500/NA	$750/NA	$1500/NA
Inpatient Mental Health Care			
Max days per calendar year	60/20	60/20	60/20
Max days per lifetime	Unlimited/60	Unlimited/60	Unlimited/60
Outpatient Mental Health Care			
Max visits per calendar year	Unlimited/26	Unlimited/26	Unlimited/26
Max visits per lifetime	Unlimited	Unlimited	Unlimited
Chemical Dependency Treatment			
Max lifetime limit	$20,000	$20,000	$20,000

Please note the following specific provisions in reviewing this schedule:

Employees who use CIGNA network providers for their mental health services do not have to satisfy a deductible before the plan begins to pay a portion of their cost. Employees who **do not** use network providers will need to satisfy a separate deductible for mental health services. Amounts applied to the deductible for mental health and chemical dependency services will not also be applied to the deductible for general medical services.

Preauthorized mental health services obtained through the CIGNA network are reimbursed by the plan at 80% for Plans A and B, and 70% for Plan C. Preauthorized mental health services that are not obtained from participating providers are reimbursed at a lower rate (60% for Plans A and B, and 50% for Plan C), subject to reasonable and customary limitations as determined by CIGNA.

Employees who obtain their preauthorized mental health care services from a contracted provider may receive full reimbursement from the plan after meeting a separate out-of-pocket maximum. Amounts applied to the out-of-pocket maximum for mental health and chemical dependency services will not also be applied to the out-of-pocket maximum for general medical services. Employees who do not use participating providers will not be eligible for full reimbursement from the plan. They must pay a portion of all charges incurred for services received from nonparticipating providers.

The lifetime benefit available for chemical dependency treatment is $20,000. This $20,000 limit is included within the $1,000,000 maximum lifetime benefit allowed under the medical plan.

All benefits paid for mental health services and chemical dependency treatment (including facility charges and supplies) are applied against the $1,000,000 maximum lifetime benefit allowed under the medical plan.

Mental and Nervous Conditions. The plans pay a percentage of preauthorized covered charges for diagnosis and treatment of mental/nervous disorders provided by a psychiatrist, psychologist, or licensed clinical social worker when the treatment is required for medical reasons. The plan also covers treatment by a licensed master's level counselor who is licensed for independent practice in the state in which he/she practices.

All services for mental and nervous conditions must be preauthorized by CIGNA to be eligible for reimbursement. Eligible services are reimbursed at a higher rate if obtained from a CIGNA network provider.

Alcoholism and Chemical Dependency Program. Inpatient and outpatient charges for alcohol or chemical dependency treatment in a hospital or licensed treatment facility are covered (to a maximum lifetime benefit of $20,000 per person) if:

The charges are part of an active treatment program and

CIGNA has pre-approved the program.

All services for alcoholism and chemical dependency treatment must be preauthorized by CIGNA to be eligible for reimbursement. Eligible services are reimbursed at a higher rate if obtained from a CIGNA network provider.

Case Management for Psychiatric Care or Chemical Dependency

Inpatient. To receive benefits under the CIGNA program, you must contact CIGNA before you or your covered dependent is confined overnight in the psychiatric unit of an acute care hospital or psychiatric hospital. Services are covered for treatment of mental illness or functional nervous disorder when the treatment is given for medical reasons and is authorized by CIGNA. Coverage for authorized inpatient mental health care obtained from a network facility

is limited to 60 days per calendar year. Coverage for authorized in-patient mental health care obtained from an out-of-network facility is limited to 20 days per calendar year. Inpatient services for mental health and chemical dependency care are reimbursed at a higher rate if obtained from a CIGNA network provider.

You must also use the CIGNA program for inpatient treatment of alcohol or chemical dependency. As indicated above, the maximum lifetime benefit payable for chemical dependency treatment is $20,000.

If you or a covered dependent need to be admitted to the psychiatric unit of an acute care hospital or psychiatric hospital, you, your physician, or your family member must call CIGNA before admission at:

1-800-455-8187.

In case of an emergency admission, you, your family member, or your physician must notify CIGNA by 5:00 p.m. of the first business day following admission. CIGNA will need the name and telephone number of the patient's provider, and the date of admission to the hospital.

A CIGNA representative will obtain necessary information and begin a case management process, working directly with the attending psychiatrist to help determine the length and medical necessity of the proposed hospital stay, and to establish follow-up review dates with the attending psychiatrist. The patient, hospital, and attending psychiatrist are notified of the results of the case management review. If you do not agree with the results, there are levels of additional review that you or the attending psychiatrist may request.

If you do not use the CIGNA program for psychiatric inpatient care, the services you obtain will not be eligible for reimbursement.

Outpatient. Outpatient treatment for mental/nervous and/or chemical dependency conditions is also subject to prior authorization by CIGNA. Coverage for authorized outpatient care obtained out-of-network will be limited to 26 sessions per year.

Inpatient and Outpatient services for mental health and chemical dependency care are reimbursed at a higher rate if obtained from a CIGNA network provider.

Mental Health Services Not Covered

The following mental health services are not eligible for reimbursement under BBWI's medical plan:

Psychoanalysis or psychotherapy when these treatments are for training, marriage counseling, amplification or perfection of vocational skills, personality improvement, and similar conditions which cannot be specifically defined as a mental illness or functional nervous disorder.

Any expense related to treatment for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, as determined by the CIGNA, and present significant symptomatic medical problems), or any treatment of obesity (except surgery to treat morbid obesity), including dietary programs (except for laboratory charges in connection with monitoring the patient's medical condition).

Any expense for sex transformations and any treatment related to sexual dysfunction.

Any testing that is psychoeducational in nature.

Hospitalization, treatment, services, supplies, or drugs that are not medically necessary as determined by CIGNA.

Charges greater than the R&C amount as determined by CIGNA.

Occupational accidents or illnesses, to the extent covered by Worker's Compensation.

Hospitalization, examinations, or medical services and supplies used for experimental procedures.

Hospitalization, examinations, or medical services and supplies which do not meet accepted standards of medical practice.

Treatment, supplies, or services in a hospital or other facility owned or operated by any government or agency, or which are paid for through a government program (except a program for civilian employees of a government).

Any services, supplies, treatment, or hospitalization provided without the recommendation and approval of a licensed physician. Reimbursement of medical charges for services is limited to those services rendered by a physician licensed to practice medicine in the state in which the charge is incurred.

Transportation or travel charges, except charges for emergency transportation within the continental United States and Canada for the first trip to and from a hospital by professional ambulance, by regularly scheduled airline, or by air ambulance to and from the nearest hospital qualified to provide special treatment for the illness.

Any expense that is incurred because of an injury or illness resulting from war or any act of war, whether declared or undeclared.

Hospitalization, examinations, or medical/surgical treatments and supplies furnished before you or your dependents were covered under this plan, or related to a period of hospital confinement before you were covered under this plan.

Charges that would not have been incurred if coverage under this plan did not exist, or that you or your covered dependents are not obligated to pay (including expenses which are the responsibility of another coverage).

Any expense for custodial care, developmental care, or domiciliary care.

Charges for personal items such as television and telephone rentals while hospitalized.

Any loss or expense resulting from a covered person's participation in a riot or in the commission of a crime.

Filing Mental Health/Chemical Dependency Claims. CIGNA providers will complete and submit your claims directly to CIGNA so that you do not have to complete any claim forms. You are responsible for paying your share of the cost and CIGNA will pay the rest.

If you use a non-network provider, the provider may require that you pay the full charges and then file a claim for reimbursement with CIGNA. Claim forms for employees who use non-network providers may be obtained from the Benefits Office at 526-2000 or by calling CIGNA at 1-800-455-8187.

Questions regarding your claim may be addressed to CIGNA at 1-800-455-8187 between 8:00 a.m. and 5:00 p.m. (CT), Monday through Friday.

Medical Plan—Administrative Information

Keeping Records. It is necessary to keep separate records of your expenses for each of your dependents and for yourself because the plan operates separately for each covered family member.

Please become familiar with the information needed on the medical claim forms. This will help you keep adequate records so that completing these forms will take less time and effort.

How Your Medical Benefits Are Coordinated. If you or your dependents are entitled to any medical benefits from any other group plan, the ***Benefits by Design*** plan will coordinate benefit payments with payments from the other plans so your **total benefit** from all plans will not be more than 100% of the medically necessary R&C charges (80% or 70% for claims that relate to mental health or chemical dependency care services). This may mean a reduction in benefits under this plan. The company will not coordinate benefits with any individual insurance you purchase on your own.

In a calendar year, this Plan will pay:

Its regular benefits in full, or

A reduced amount of benefits. To figure this amount, subtract (B) from (A) below:

(A) 100% of "Allowable Expenses" incurred by the person for whom claim is made (80% or 70% in the case of mental health or chemical dependency services).

(B) The benefits payable by the "other group plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any necessary and reasonable health expense, which is covered under this plan for the person for whom claim is made.

The difference between the cost of a private hospital room and the semiprivate rate is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

Plans that coordinate benefits with the medical plan are:

Group, blanket, or franchise coverage (except student accident insurance)

Group prepayment plans, including Health Maintenance Organizations (HMOs)

Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans

Any coverage under governmental programs, and coverage required or provided by law, except for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, or Medicaid

Other insured or self-insured group coverage.

You must provide information about any additional medical coverage you or your covered dependents have on your claim form. If you do not report other group insurance coverage, claim processing could be delayed.

Which Plan Pays First. To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

A plan which covers a person other than as a dependent (for example, as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. An exception to this rule is made when the person is also covered by Medicare, and Medicare is both (1) secondary to the plan covering the person as a dependent, and (2) primary to the plan covering the person as other than a dependent. In this situation, the benefits of the plan which covers the person as a dependent will be determined first.

A plan covering the person as an employee (who is neither laid off nor retired), or as that employee's dependent, pays before a plan covering a person who is laid off or retired (or that employee's dependent). However, if the other plan does not have this rule and the order of benefit payment does not agree between the two plans, this rule does not apply.

A plan covering the person under a right of continuation pursuant to federal or state law pays after any other plan which covers the person other than such right of continuation. However, if the other plan does not have this rule, and the order of benefit payment does not agree between the two plans, this rule does not apply.

Except in the case of a dependent child whose parents are divorced or separated, if a child is covered under both parents' plans:

- The plan of the parent whose birthday falls earlier in a year pays first
- If both parents have the same birthday, the plan covering the parent longer pays first

- If the other plan does not use the "birthday rule" described above, but instead has a rule based on the gender of the parent, the rules of the other plan will determine the payment order of benefits if different from the order described under this plan.

In the case of a dependent child whose parents are divorced or separated:

- If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the "birthday rule" provisions described above will apply.

- If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

- If there is not a court decree and two or more plans cover a child, the plan of the parent with custody of the child pays first (if the parent has not remarried).

- If there is not a court decree and the custodial parent has remarried, that parent's plan will pay benefits first, the stepparent's plan second, and the plan of the parent without custody pays third.

If none of the above provisions determine the order of benefit payments, the benefits of the plan covering a person longer are determined first, except that

- The benefits of a plan which covers the person as a laid-off or retired employee, or the dependent of such person, shall be determined after the benefits of any other plan which covers such person as an employee who is not laid-off or retired, or a dependent of such person. If the other plan does not have a provision regarding laid-off or retired employees, this provision will not apply.

- The benefits of a plan which covers the person under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

Aetna (or CIGNA/Eckerd's as appropriate) has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Third Party Reimbursement. In some cases, this plan may pay expenses for an injury or illness that was caused by another person who could be legally responsible for those expenses. If

that happens, this plan has the right to be repaid or reimbursed from any amounts you may recover from that person or organization.

If you suffer a loss or injury caused by an act or omission of another person, benefits under this plan will be paid only if you (or your legally authorized representative) agree in writing to:

Reimburse Aetna, up to the full amount of benefits paid under the plan, if damages are collected (subject to applicable law). Damages may be collected by action of law, settlement, or otherwise.

Provide Aetna with a lien against amounts which may be recovered, equal to the benefits you receive under the plan. This lien may be filed with the third party (from whom damages may be collected), the third party's agent, or a court with jurisdiction over the matter.

The payment and the lien referred to above shall be made or provided to Aetna in its capacity as the provider of administrative services to the plan.

This provision protects the plan's rights to recover any amounts that are paid to you or on your behalf, pending resolution of issues regarding payment liability by the other person and/or his/her agent.

When Your Coverage Ends.

Employee. Your medical coverage will end on the earliest of the following:

The last day of the month in which your full-time employment ends, except as permitted under COBRA.

The last day of the month in which you retire, except as permitted under the section titled "Your Benefits at Retirement."

The last day of the month in which you are no longer eligible.

The first day of the month in which you no longer make any required contributions for coverage.

The last day of the period for which your last required payment is made (as in COBRA).

The day on which the plan ends.

You may continue coverage while you are on unpaid leave of absence (including time off without pay, family medical leave, inactive employee status) only if you continue to pay your monthly cost of coverage during the leave.

Dependents. Medical coverage for your dependent(s) ends on the earliest of the following:

The day your coverage ends, except as permitted under the section titled "Retirement."

The last day of the month in which your dependent is no longer eligible for coverage.

The last day of the month in which the dependent becomes an employee of the company.

The first day of the month in which you no longer make contributions for dependent coverage.

The last day of the period for which the last required payment is made by the participant (as in COBRA).

The day on which the plan ends.

Survivor Medical Benefits. If you die while covered under the medical plan, coverage for your covered dependent(s) will continue until the earliest of the following:

Three months after the end of the month in which you die.

The last day of the month in which your dependent(s) is no longer eligible for coverage.

The last day of the month in which your dependent(s) becomes eligible for Medicare.

The first day of the month in which your dependent(s) no longer makes contributions for coverage.

The day on which the plan ends.

Your dependents may be eligible to elect continued coverage under COBRA or to convert their coverage by making appropriate application and paying the cost for the coverage.

Medicare. You will be eligible for coverage under the ***Benefits by Design*** medical plan as long as you remain employed at the INEEL and subject to other eligibility provisions as described previously. If you are still employed full-time at age 65, when your Medicare coverage begins, you may file claims with the ***Benefits by Design*** medical plan as the primary payor and with Medicare as the secondary payor.

The company strongly recommends that you visit your local Social Security Office before you reach age 65 so that all available benefits can be properly explained to you. You may want to apply for Medicare Part B coverage at age 65, even though the BBWI plan is the primary payor.

The company will **not** reimburse Medicare Part B premiums.

More information about Medicare may be obtained by contacting the Social Security Administration.

Your Benefits at Retirement. If you retire *early* (as defined in the INEEL Employee Retirement Plan) and continue to pay the required premiums, you may continue your medical coverage currently in effect until you become eligible for Medicare Part A due to age or disability. (Please note that retirees may continue their coverage either under the provisions of this section, or under COBRA as described in the pages that follow.) You may also cover your dependent(s) who are covered under the plan when you retire until they (1) are no longer eligible for coverage, or (2) become eligible for Medicare Part A due to age or disability, whichever is earlier.

If you elect *normal* retirement, as defined in the INEEL Employee Retirement Plan, you may continue dependent coverage until your dependent is no longer eligible for coverage or becomes eligible for Medicare Part A (due to age or disability), whichever is earlier. Alternatively, your dependents may continue their medical coverage under COBRA as described in the pages that follow.

Subsequent to retirement, retirees may add their eligible dependents who are already covered under the plan (for example, a dependent who is already covered as an active employee). Additionally, retirees may add dependents to their coverage during annual enrollment or if they experience a qualified family status change.

After you retire and become eligible for Medicare Part A, coverage for your eligible dependent(s) will continue if you continue to pay the full "retiree and dependent" premium. Please be aware, however, that coverage for your dependent children will terminate when both you and your spouse are no longer covered.

If you retire and become employed by another company, and if you are covered under that company's group medical plan, that plan will have primary payment responsibility and the ***Benefits by Design*** plan will provide secondary benefits.

The company reserves the right to change the terms and conditions of retiree coverage, and the cost of retiree coverage, at any time.

Conversion Privilege. The plan may allow you and your covered dependents to obtain from Aetna, at your own expense, a personal medical policy without proof of good health upon your ineligibility to be covered by the company group plan. Please note, though, that benefits under your conversion policy will generally not be as extensive as benefits under the ***Benefits by Design*** plan. (See limitations below.)

You will be eligible to take advantage of this provision when your coverage ends (including your continuation rights under COBRA) because (1) your employment terminates due to retirement or otherwise, or (2) you are no longer eligible for medical coverage. Please be aware that if your employment ends due to retirement and you choose to continue retiree medical coverage, you will not be able to later convert your coverage to a separate policy under this provision. Also,

you may not convert if your coverage ends because the group contract for medical coverage is discontinued.

The conversion privilege is also available to your eligible dependents if their coverage terminates (including continuation of coverage under COBRA) because (1) your coverage ends, (2) you die, or (3) they cease to qualify as dependents under the plan.

To be eligible for the conversion privilege, you or your dependent(s) must apply and submit the first premium within 30 days after your coverage ends. Contact your Benefits Office for further information about converting your coverage.

Aetna may decline to issue you and/or your dependents a personal conversion policy if:

It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.

On the date of conversion, a person is covered, eligible or has benefits available under one of the following:

- Any other hospital or surgical expense insurance policy.
- Any hospital service or medical expense indemnity corporation subscriber contract.
- Any other group contract.
- Any statute, welfare plan or program.

Also, no person will be eligible to convert to an individual policy if:

He/she has not been covered under the plan for at least three months.

He/she has used up the $1,000,000 maximum lifetime benefit.

He/she becomes eligible for other coverage under this plan.

As noted above, coverage under your conversion policy will generally not be as extensive as coverage under the ***Benefits by Design*** plan. For example, the level of coverage may be less and an overall lifetime maximum benefit will apply.

Additionally, the personal policy may contain either or both of:

A statement that benefits under the personal policy will be cut back by any like benefits payable under this Plan after your coverage ceases.

A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not provide the

requested data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under such other plans.

The personal policy will state that Aetna has the right to refuse renewal under conditions which are specified in the policy.

Extended Benefits-Disability. If you or one of your dependents is totally disabled as a result of a nonoccupational medical condition when your medical coverage under this plan ends for any reason, benefits for that disability only will be continued to the end of the calendar year following the year in which your coverage ends. However, medical coverage will end automatically when the disabled person is eligible for benefits under any other group plan (including Medicare, COBRA, etc.) or is no longer totally disabled.

Continued Coverage (COBRA). If you or your dependent(s) become ineligible for coverage under the ***Benefits by Design*** medical plan, continued coverage as provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA) may be available if you (or your dependents) enroll and pay the applicable costs. Except in cases where coverage is extended due to disability, your cost for this coverage is 102% of the full cost of coverage.

Eligibility for Continued Coverage. To be eligible for continued coverage (COBRA), you or your dependent(s) must be covered under the ***Benefits by Design*** medical plan immediately before you request continued coverage. You may elect to continue the same medical coverage you enjoy as an active employee. (however you will not pay the same contribution that you paid under the Benefits by Design plan.)

You and your covered dependent(s) may continue coverage through COBRA when regular coverage ends due to one of the following events:

Your full-time employment ends.

Your employment status changes from regular full-time to temporary or part-time.

Continued coverage is also available to your covered dependents when their regular coverage ends due to one of the following events:

You die.

You become divorced or legally separated.

Your dependent ceases to be eligible for coverage.

You become eligible for Medicare Part A benefits.

Duration of Continued Coverage. Continued coverage for you and your eligible dependents may extend for up to **18 months** after you end full-time employment or your employment status changes.

Continued coverage for your dependents may extend for up to **36 months** after your death, divorce, legal separation, or eligibility for Medicare Part A. Additionally, your dependents may continue their coverage for 36 months if they become ineligible for coverage.

Coverage may end sooner than the times specified above if one of the following events occurs:

The cost for a covered individual is not paid within 30 days following the first of the month for which the payment is due. (For example, if the payment for January is not paid by January 31.)

The covered person becomes eligible, while on COBRA, for Medicare Part A benefits or becomes covered under another group health plan (unless the plan does not cover a pre-existing condition of the covered person).

The ***Benefits by Design*** plan ends.

If You Are Disabled. Generally, if you or a covered dependent is disabled, the disabled person will be eligible for continued coverage for up to 18 months, whether or not he/she meets the Social Security Administration's definition of "disabled."

Additionally, continued coverage may be extended **after** 18 months if you or your dependent is disabled as defined by Social Security either **on the date** your employment ends (or within 60 days thereafter) or, alternatively, on the effective date of an employment status change that makes you and your dependents eligible for continued coverage.

Under these circumstances, the disabled person will be eligible to continue coverage for up to 11 additional months (up to 29 months **total**). Non-disabled dependents (of the disabled person) who are entitled to COBRA coverage are also eligible for the 11-month extension of coverage. To elect an extension of continued medical coverage for a person who is determined to be disabled under Social Security, you must notify the Plan Administrator by the earlier of (1) 60 days after the person is declared disabled, or (2) the last day of the initial 18-month coverage continuation period. The cost of coverage for the additional 11 months will be 150%, rather than 102%, of the full cost of coverage.

Continued coverage for disability may end sooner than 29 months if you or your dependent is no longer considered disabled by Social Security. Coverage for non-disabled dependents would end if your own coverage were to terminate before the end of the 29-month period.

Election Period/Notification. You have a certain period of time in which to elect continued coverage. If you do not elect continued coverage during this period, or if you give up your right

to continued coverage, your decision is considered final. You will not have another opportunity to elect continued coverage.

The company will notify you, or your dependent(s) if applicable, of the right to continue coverage under COBRA as soon as the company is aware that regular coverage will end because you end active employment, retire, become eligible for Medicare Part A benefits, change your employment status, or die. You or your dependent(s) have 60 days from that notification or the date of the event (whichever is **later**) to elect continued coverage.

You or your covered dependent(s) must notify the Benefits Office within 60 days if eligibility ends due to divorce or your dependent child losing eligibility. The company will then notify you or your dependent(s) of the right to continue coverage. You or your dependents have 60 days from notification by the company to elect continued coverage.

Paying for Continued Coverage. If you or your dependents elect continued coverage, the cost of at least the first month of coverage must be paid within 45 days after you elect continued coverage. You will be charged from the date you become eligible for continued coverage, regardless of when you elected the coverage during the election period. To ensure timely reporting of coverage eligibility and avoid delay in processing your claims, you should remit the contribution amount before the first of the month for which the payment is being made. Your coverage will be terminated without notice if the Benefits Office does not receive your payment within 30 days after the first of the month for which the payment is due.

Payment of Claims. If you or your dependent(s) elect to continue coverage when it is first offered, claims will be payable from the effective date of coverage. However, claims cannot be processed unless you have paid the cost of coverage.

If you or your eligible dependents **do not** elect to continue coverage (COBRA), the ***Benefits by Design*** plan will not pay benefits for expenses you or your dependents have after the date your coverage ends. This applies **even if** the condition being treated began while you or your dependents were covered by the plan. The only exception is if you or your dependent(s) are totally disabled. (See Extended Benefits—Disability).

Definitions

Benefits by Design is a flexible benefit plan offered by the company.

Company means Bechtel BWXT Idaho, LLC.

Custodial care means services and supplies (including board, room, and other institutional care) furnished to a person mainly to help him/her with the activities of daily life, without regard to (1) who prescribes the services, (2) who recommends the services, or (3) who performs the services. The person does not have to be disabled.

Disabled (totally) means you are not able to perform any of the usual and customary duties of any occupation. For dependents, this means your dependent cannot perform any of the usual and customary duties or activities of a person in good health and of the same age.

Durable medical equipment is no more than one item of equipment for the same or similar purpose (such as a hospital bed, wheelchair, etc.) and the accessories needed to operate it. Durable medical equipment is:

Made to withstand prolonged or repeated use.

Made for and primarily/customarily used to treat a disease or injury.

Not generally useful to the person in the absence of an illness or injury.

Appropriate for use in the home.

Not for use in altering air quality or temperature.

Not for exercise or training.

Durable medical equipment does not include nonmedical equipment, such as sun or heat lamps, heating pads, whirlpool baths or spas, portable whirlpool pumps, sauna baths, massage devices, overbed tables, exercise devices, ramps, handrails, elevators, communication aids, vision aids, telephone alert systems, air conditioners, air purifiers and humidifiers.

Emergency admission means an admission in which a physician admits the person to a hospital or treatment facility immediately following the sudden and (at that time) unexpected onset of a change in a person's physical or mental condition which:

Necessitates immediate confinement as a full-time inpatient, and

Can be reasonably expected (as determined by Aetna) to result in loss of limb/life, significant impairment of bodily function, or permanent dysfunction of a body part if immediate inpatient care is not given.

Employee means a regular full-time employee of the company.

Extended care facility (skilled nursing care facility) is an institution (or distinct part of an institution) that:

Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury.

- Professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N., and

– Physical restoration services to help patients to meet a goal of self-care in daily living activities.

Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.

Is supervised full-time by a physician or R.N.

Keeps a complete medical record on each patient.

Has a utilization review plan.

Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.

Charges a fee for services rendered.

The plan will pay extended care facility benefits only if:

The confinement is under the supervision of a physician, and

Hospital confinement would be necessary in the absence of extended care facility confinement.

Home health agency is a public agency or private organization, licensed and operated in accordance with state law, that:

Primarily provides skilled nursing services and other therapeutic services.

Has policies developed with the advice of a group of professionals, including at least one physician and at least one registered professional nurse (R.N.), to govern the services provided, and has a physician or registered professional nurse supervise health care services.

Maintains clinical records on all patients.

Is licensed under state or local laws, or meets the licensing standards of the state or local area.

Meets other conditions established under Medicare to protect the health and safety of individuals who receive home health care services.

Home health care plan means a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

Prescribed in writing by the attending physician; and

An alternative to confinement in a hospital or convalescent facility.

Hospice care is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice care agency is a public agency or private organization that provides care and services for terminally ill persons and their families. The hospice must meet Medicare requirements, or meet all of the following requirements:

Provide Hospice Care services 24-hours-per-day.

Provide skilled nursing services, medical social services, and psychological/dietary counseling.

Provide or arrange for other services including services of a physician, physical/occupational therapy, part-time home health services which consist mainly of caring for terminally ill persons, and inpatient care in a facility when needed for pain control and acute/chronic symptom management.

Have a staff of employees that includes at least one physician, one registered professional nurse (R.N.), and one social worker to coordinate the care and services provided.

Establish policies governing the provision of Hospice Care.

Assess the patient's medical and social needs and develop a Hospice Care Program to meet those needs.

Provide an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.

Permit all area medical personnel to utilize its services for their patients.

Keep a medical record on each patient.

Utilize volunteers trained in providing services for non-medical needs.

Have a full-time administrator.

Be licensed, certified, or accredited as a hospice, if required by local laws.

Hospice care program is a written plan of hospice care which:

Is established by, and reviewed from time to time by, (1) a physician, and (2) appropriate personnel of the Hospice Care Agency.

Is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families.

Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital is an institution licensed by the state as a hospital, approved as a general hospital by the Joint Commission on the Accreditation of Hospitals (JCAH), and operated in accordance with the laws for care and treatment of sick and injured persons. The hospital must (1) be supervised by a staff of physicians, (2) provide 24-hour nursing care and (3) have facilities for medical diagnosis, surgery (unless the hospital primarily treats chronic illnesses), treatment, and care of injured and sick persons. For the purpose of this definition the Idaho Falls Recovery Center, licensed by the State of Idaho, will be considered a hospital.

A fully state-licensed treatment facility approved under the ***Benefits by Design*** plan that primarily treats alcohol or chemical dependency will also be considered a hospital for benefit purposes when you or your dependent is confined under an active treatment program (up to 30 days continuous confinement or as otherwise approved by the plan administrator).

"Hospital" does **not** include hotels, rest homes, convalescent homes, places for custodial care, nursing homes, or homes for the aged.

Hospital confinement means a medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board and regardless of how the hospital classifies the stay. Any hospital confinement satisfying this definition will be subject to all policy provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements.

Injury is a bodily injury sustained accidentally by external means.

Medical emergency is a severe condition that, in the opinion of Aetna's medical staff and/or an independent medical review (or CIGNA for mental health and chemical dependency situations):

Results in symptoms that occur suddenly and unexpectedly, and

Requires immediate care by a physician to prevent death or serious impairment of the covered person's health.

Medically necessary. Services or supplies are those furnished by a particular covered provider which Aetna (CIGNA for mental health and chemical dependency services or Eckerd's for prescription drugs) determines are appropriate for the diagnosis, care or treatment of the disease or injury involved.

To be appropriate, the service or supply must:

Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply both as to the disease or injury involved and the person's overall health condition.

Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition.

As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances. Aetna (or CIGNA/Eckerd's as appropriate) will take into consideration all of the following:

Information provided on the affected person's health status.

Reports in peer reviewed medical literature.

Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data.

Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment.

The opinion of health professionals in the generally recognized health specialty involved in such opinion.

Any other relevant information brought to the attention of Aetna (or CIGNA/Eckerd's as appropriate).

In no event will the following services or supplies be considered to be medically necessary:

Those that do not require the technical skills of a medical, a mental health or a dental professional.

Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility.

Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined in a hospital.

Those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Morbid obesity is a condition as determined in accordance with Aetna's underwriting standards.

Network provider means:

A hospital, physician or other provider of health care services/products recognized by the plan that has entered into a written agreement with CIGNA, Eckerd's or CCN-Premier (on behalf of the Southeast Idaho Employers Coalition) to provide health care services to covered persons under the plan at pre-negotiated rates.

Radiologists, anesthesiologist, pathologist, emergency room, and other physicians who are network hospital-based will be considered Network Providers if a covered person utilizes a network hospital for services related to a hospital confinement or a surgical procedure. Additionally, charges by out-of-network laboratories, radiologists, anesthesiologists, and pathologists will be reimbursed at the in-network schedule of benefits if the services obtained are the result of referral by a network provider. Allowable expenses for services and supplies furnished by such providers shall be based on reasonable and customary charges.

A provider may be named by the company as an exclusive provider. Allowable expenses for services and supplies furnished by such providers shall be based on reasonable and customary charges.

Non-network provider means a hospital, physician or other health care provider that has not entered into a written agreement with CIGNA, Eckerd's or CCN-Premier (on behalf of the Southeast Idaho Employers Coalition) to provide health care service products to Covered Persons under the plan at pre-negotiated rates.

Nonoccupational injury or illness is an accidental bodily injury or illness that does not (1) arise out of, or in the course of, any work for pay or profit, or (2) result in any way from an injury which does. An injury or illness will be deemed to be nonoccupational (regardless of cause) if proof is furnished that the person is covered by Worker's Compensation, but is not covered for that injury or illness.

Physician is a person legally licensed to practice medicine and perform surgical procedures, or any other licensed health care practitioner that state law requires to be recognized as a physician for purposes of group insurance coverage.

Reasonable and customary charge for a service or supply is the lowest of the following amounts:

The provider's usual charge.

The charge Aetna (or CIGNA as appropriate) determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made.

The charge Aetna (or CIGNA as appropriate) determines to be the 90th percentile of prevailing charges for that service or supply.

In determining reasonable and customary charges for services/supplies that are unusual, infrequently provided, or provided by only a small number of area providers, Aetna (or CIGNA as appropriate) may take into account factors such as:

The complexity of the services.

The degree of skill needed.

The type of specialty of the provider.

The range of services or supplies provided by a facility.

The recognized charge in other areas

DENTAL PLAN

Summary of Dental Benefits

Benefits by Design offers two dental plans—Plan A and Plan B—to help you pay for routine dental costs that result from preventive, therapeutic, and medically necessary restorative treatment. The dental plan does not cover orthodontic services.

Employees who choose dental coverage will be covered under the plan selected for **two plan years if they continue to be eligible for coverage**. Similarly, employees who waive dental coverage generally may not enroll for coverage for two plan years. (The plan year is the same as the calendar year, from January 1 through December 31.)

Plan Features. Both dental plans cover the same dental expenses. However, Plan B provides a higher level of coverage than Plan A for most services.

Dental coverage is provided by the Delta Dental Plan, using a program that includes contracted member providers. Although employees may go to any dentist, it is to their advantage to choose a Delta member dentist to minimize their out-of-pocket expenses.

If you obtain your dental services from a Delta dentist, you will only have to pay the amount of your deductible and copayment for covered services. Delta dentists will submit your dental claims for you and are not allowed to bill you additional amounts for charges that exceed negotiated rates. There are approximately 540 participating Delta dentists in Idaho and over 113,000 nationally. You may obtain a list of the participating Delta dentists in your area by contacting Delta Dental at 1-800-427-3237. Additionally, you may access this information through the direct link from the Benefits Homepage to the Delta Dental website.

The features of the two dental options are detailed below:

Plan Features	Plan A	Plan B
Annual Deductible		
Per person	$50	$25
Per family	$150	$75
Plan Pays:*		
Preventive services (no deductible required)	100%	100%
Diagnostic services	50%	100%
Minor restorative services	50%	80%
Major restorative services and prosthodontic services	50%	50%
Maximum benefit per person per year	$750	$1,500

*Subject to plan definitions and limits.

Dental Plan Costs. Your contributions for dental coverage are withheld from your paycheck on a pre-tax basis. The cost depends on the plan you choose and the coverage classification you select (employee only, employee and family, employee and children, or employee and spouse). You are not required to choose the same classification of dental coverage as you choose for medical coverage.

The company provides credits to offset against the cost of the dental plan you choose. Alternatively, if you don't wish to participate, you may opt out of the dental plan and receive a cash credit of $5 as an addition to your monthly pay (subject to normal income tax withholding), provided you are not covered under the dental plan as a dependent of your spouse.

Covered Expenses

The following services are covered under the dental plans. Please note that if the charge is for a service or supply that has an appropriate alternative under accepted standards of dental practice, only the usual, customary, and reasonable (UCR) charge for the less costly procedure, service, or supply will be considered a covered dental expense. If a procedure, supply, or service is provided by a nonparticipating dentist, payment is based on the lesser of the actual charge or the UCR allowance.

Preventive Services. Preventive services and supplies are covered at **100%** of UCR charges with **no deductible**. These services include:

Oral examinations – twice each calendar year

Routine prophylaxis – teeth cleaning twice each calendar year

Fluoride treatment by a dentist or dental hygienist to apply stannous fluoride twice each calendar year for covered children age 19 and under

Space maintainers (initial appliance), including installation, fitting, and adjustments within 6 months of installation for covered children under age 16

Emergency dental procedures performed to temporarily alleviate or relieve acute pain, discomfort, or distress, but which do not necessarily effect a definite cure

Panoramic film, once every 3 years

Bitewing x-rays twice each calendar year and full-mouth x-rays once every 3 years

Dental sealants applied to the first and second permanent molars (without decay, without restorations, and with the occlusal surface intact), for eligible persons under age 25 when the teeth have not been treated with sealants for at least 4 years.

Diagnostic Services. Diagnostic services are covered at **50%** or **100%** of UCR (depending on the plan and provider that you choose) after you have paid the annual dental plan deductible. These services include:

Dental exams and specialist consultations performed in connection with the diagnosis of a specific condition requiring treatment

Dental x-rays requested in connection with the diagnosis of a specific condition requiring treatment

Tests and laboratory examinations, including pulp vitality tests, biopsy tissue examinations, and study model diagnostic casts.

Oral Surgery, Minor Restorative Services and Supplies. Minor restorative services and supplies are covered at **50%** or **80%** of UCR (depending on the dental plan and provider that you choose) after you have paid the annual dental plan deductible. These services include:

Periodontics–treatment of periodontal diseases of the gums and tissues of the mouth, including gingivectomy, gingival curettage, and osseous surgery (including post-surgical visits), pedicle soft tissue grafts, occlusal adjustments, and occlusal guards related to periodontal surgery.

Also includes periodontal examinations and cleanings in accordance with Delta Dental guidelines. Both regular cleanings and periodontal cleanings, or any combination thereof, are limited to two in a calendar year.

Endodontic procedures (procedures such as a root canal, used for treatment of dental pulp).

Application of desensitizing medicaments.

General anesthetics and their administration, including intravenous sedation, when performed in conjunction with cutting procedures in the oral cavity or when other desensitizing medications are not effective.

Antibiotic drug injection by the attending dentist.

Visits and professional consultation by someone other than the treating dentist.

Amalgam, synthetic porcelain, and plastic filling restorations to restore diseased or accidentally broken teeth. Only the material used in accordance with accepted dental practices (not cosmetic) having the lesser charge will be covered.

Repair or recementing of crowns, inlays, onlays, fixed or removable dentures; or relining or rebasing dentures more than 6 months after installation of an initial or replacement denture, but not more than one relining or rebasing in any 24-month period.

Oral surgery, including necessary pre-operative treatment during medically necessary hospital confinement and customary post-operative treatment furnished in connection with oral surgery, such as:

- Extractions
- Alveolectomy, alveoplasty, stomato-plasty, and frenulectomy; excision of pericoronal gingiva, exostosis, hyperplastic tissue, and oral tissue for biopsy and tooth replantation
- Any other oral surgery involving any tooth structure, alveolar process, or gingival tissue, except removal of a tumor or cyst or incision and drainage of an abscess or cyst.

Major Restorative and Prosthodontic Services. Major restorative and prosthodontic services are covered at 50% of UCR (subject to a review of medical necessity by Delta Dental) after you have paid the annual dental plan deductible. These services include:

The restoration of missing teeth by artificial means, such as bridgework and dentures, including initial installation if teeth are extracted while covered under this plan. Replacement of bridgework and dentures are covered if installed at least five years prior to the replacement and if they cannot be repaired (as determined by Delta Dental). Check with Delta Dental for full details on this coverage.

Inlays, onlays, gold fillings, or crown restorations (including stainless steel) to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries and fractures, cannot be restored with an amalgam, synthetic porcelain, or plastic filling restoration. When a tooth can be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration, benefits will be determined based on such a restoration.

Replacement of an existing inlay, onlay, gold filling, or crown restoration as described above. However, if such appliance is installed while you are covered under this plan, at least 5 years must have elapsed before it may be replaced. The only exception is if replacement is required as a result of accidental bodily injury sustained while covered under this plan.

Implants or their removal are not covered under this plan. However, if implants are provided in association with a covered prosthodonic appliance, Delta will allow the cost of a standard complete or partial denture toward the cost of the implant procedures and prosthodontic appliances. In this event, Delta will not pay for any replacement placed within five years thereafter.

Predetermination of Dental Benefits

If your dental treatment involves services costing $100 or more, or if you will be receiving major restorative or prosthodontic services (as described earlier), it is advisable to ask your dentist to submit a predetermination of benefits.

A statement will be sent to your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. Please note that claims for other completed dental services received and processed prior to the completion date of the proposed treatment may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predetermination estimates are valid for 90 days from the date issued by Delta Dental, subject to your continued eligibility in the Plan and the continuation of Delta Dental's contract with BBWI.

Dental Services Not Covered

Services **not** covered under the plans include, but are not limited to, the following:

Procedures, services, or supplies primarily for cosmetic purposes, including charges for personalization or characterization of dentures and precision attachments.

Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Replacement of a lost, missing, or stolen duplicate prosthetic device or other dental appliance.

Implantology, including implants and appliances constructed in association with implants, and the surgical removal of implants (except as noted above under Major Restorative Services); and for other procedures, services, or supplies which are experimental.

Appliances or restorations considered by Delta Dental to be necessary to alter, restore, or maintain occlusion, or to increase vertical dimension, including, but not limited to, treatment and diagnosis of temporomandibular joint (TMJ) syndrome, splinting, and replacing tooth structure lost as the result of abrasion or attrition.

Charges for periodontal splinting of teeth, except for provisional, intracoronal stabilization of mobile teeth.

Drugs and/or medications, (including prescriptions, applied therapeutic drugs, premedications, and analgesia), other than injection of antibiotics.

Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.

Hospital charges and any additional fees charged by the Dentist for hospital treatment, unless determined to be medically necessary by Delta Dental.

Services for injuries or conditions which are compensable under Worker's Compensation.

Services for which you or your dependent(s) are not required to pay and services provided by any Federal or State Government Agency.

Charges incurred after coverage ends, except as noted elsewhere in this handbook.

Procedures, services or supplies started before you or your dependents became covered under the plan.

Procedures, services or supplies furnished by someone other than a licensed, legally qualified dentist, acting within the scope of his or her license. The only exception is for charges performed by a licensed dental hygienist acting within the scope of his or her license and under the supervision and direction of a legally qualified dentist.

Replacement of existing restorations for any purpose other than restoring active tooth decay.

Facings on pontics or crowns posterior to the second bicuspid.

Procedures, services, or supplies that are not necessary according to acceptable standards of dental practice, or do not meet acceptable standards of dental practice, including charges for procedures, services, or supplies that are experimental.

Procedures, services, or supplies furnished because of an injury, disease or dental defect resulting from war or any act of war, declared or undeclared.

Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis, and anodontia.

Diagnosis or treatment by any method of any condition related to TMJ syndrome.

Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

Precision attachments, except when they are the sole method of completing a course of treatment.

Orthodontic services.

Using Your Dental Program

Filing Claims. Under the Delta Dental Program you are free to go to the dentist of your choice. If your dentist is a participating dentist, the claim form will be available at the dentist's office. The dental office will file the claim form with Delta Dental; however, you may be required to assist in completing the patient information portion of the form.

If you go to a nonparticipating dentist, you may obtain a claim form from the Benefits Office, the company reception desks in Idaho Falls, or the various medical dispensaries. Delta Dental also accepts the standard ADA claim form used by most dentists. Claims must generally be submitted to Delta within six months of the date of service.

During your first dental appointment, it is very important to advise your dentist of the following information:

Your Delta Group Number (5440)

Your employer's name (BBWI)

Your Social Security number (your dependents must use YOUR Social Security number)

Your birthday and those of your eligible covered dependents.

Please answer all questions on the claim form. If you do not answer all questions, your claim processing will be delayed.

Questions regarding your dental claim payment or coverage should be addressed directly with your Delta dentist. If you use a nonparticipating dentist and have questions regarding your claim or coverage, please call Delta Dental at **1-800-548-5468.**

Please note that charges for services of non-participating dentists will not be eligible for processing unless your claim is filed within 12 months of the date such services are provided.

Claim Review. The Dental Consultant of Delta Dental and/or any other dentist whom Delta Dental may designate shall have the right to resolve any question concerning coverage of dental services (or the necessity or choice of treatment) which may arise hereunder. Any such determination made in good faith shall be conclusive and binding upon Delta Dental, the patient and the dentist, unless within 90 days following receipt of written notice of the rejected procedure or other written notice of such decision, any person aggrieved thereby shall appeal the same to Delta Dental for determination by a second dentist. When appealing a denial of benefits, please include the group name (BBWI) group number (5440), name, employee's social security number and a phone number, in addition to a copy of the treatment form, notice of payment, and any other relevant information. Such second determination shall be final and binding on all parties and not subject to any further appeal, arbitration or judicial review.

Any controversy or claim arising out of or relating to this contract or the breach thereof, other than a question concerning coverage of dental services or the necessity or choice of treatment which is to be determined under the provisions above, shall be settled by arbitration in accordance with the arbitration statutes of the State of Idaho in effect at that time, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The rules of the American Arbitration Association shall be followed in such arbitration proceeding.

Keeping Records. It is necessary to keep separate records of your expenses for each of your dependents and for yourself because the plans operate separately for each covered family member. You should become familiar with the information needed to file a dental claim in order to keep records that will save you time and effort when you submit claim forms.

How Your Dental Benefits Are Coordinated

If you or your dependents are entitled to any dental benefits from any other group plan, the ***Benefits by Design*** plan will coordinate benefit payments with payments from the other plans so your **total benefit** from all plans will not be more than 100% of the medically necessary R&C charges. This may mean a reduction in benefits under this plan. The company will not coordinate benefits with any individual insurance you purchase on your own.

In a calendar year, this Plan will pay:

Its regular benefits in full, or

A reduced amount of benefits. To figure this amount, subtract (B) from (A) below:

(A) 100% of "Allowable Expenses: incurred by the person for whom claim is made.

(B) The benefits payable by the "other plans." (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

Plans that coordinate benefits with the dental plan are:

Group, blanket, or franchise coverage (except student accident insurance)

Group prepayment plans, including Health Maintenance Organizations (HMOs)

Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans

Any coverage under governmental programs, and coverage required or provided by law, except for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, or Medicaid

Other insured or self-insured group coverage.

You must provide information about any additional dental coverage you or your covered dependents have on your claim form. If you do not report other group insurance coverage, claim processing could be delayed.

Which Plan Pays First. To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

A plan which covers a person other than as a dependent (for example, as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. An exception to this rule is made when the person is also covered by Medicare, and Medicare is both (1) secondary to the plan covering the person as a dependent, and (2) primary to the plan covering the person as other than a dependent. In this situation, the benefits of the plan which covers the person as a dependent will be determined first.

A plan covering the person as an employee (who is neither laid off nor retired), or as that employee's dependent, pays before a plan covering a person who is laid off or retired (or that employee's dependent). However, if the other plan does not have this rule and the order of benefit payment does not agree between the two plans, this rule does not apply.

A plan covering the person under a right of continuation pursuant to federal or state law pays after any other plan which covers the person other than such right of continuation. However, if the other plan does not have this rule, and the order of benefit payment does not agree between the two plans, this rule does not apply.

Except in the case of a dependent child whose parents are divorced or separated, if a child is covered under both parents' plans:

- The plan of the parent whose birthday falls earlier in a year pays first
- If both parents have the same birthday, the plan covering the parent longer pays first
- If the other plan does not use the "birthday rule" described above, but instead has a rule based on the gender of the parent, the rules of the other plan will determine the payment order of benefits if different from the order described under this plan.

In the case of a dependent child whose parents are divorced or separated:

- If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the dental care expenses of the child, the "birthday rule" provisions described above will apply.

- If there is a court decree which makes one parent financially responsible for the dental care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

- If there is not a court decree and two or more plans cover a child, the plan of the parent with custody of the child pays first (if the parent has not remarried).

  If there is not a court decree and the custodial parent has remarried, that parent's plan will pay benefits first, the stepparent's plan second, and the plan of the parent without custody pays third.

If none of the above provisions determine the order of benefit payments, the benefits of the plan covering a person longer are determined first.

Delta Dental has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Subrogation. In some cases, this plan may pay expenses for an injury or illness that was caused by another person who could be legally responsible for those expenses. If that happens, this plan has the right to be repaid or reimbursed from any amounts you may recover from that person or organization.

You will be required to authorize an assignment or other legal document on behalf of the plan to protect the plan's rights to recover any amounts that have been paid to you or on your behalf.

When Your Coverage Ends

Employee. Your dental coverage will end (except as permitted under COBRA) on the **earliest** of the following:

The last day of the month in which your full-time employment ends.

The last day of the month in which you retire.

The last day of the month in which you are no longer eligible.

The first day of the month in which you no longer make any required contributions for coverage.

The day on which the plan ends.

You may continue coverage while you are on unpaid leave of absence (including time off without pay, family medical leave, inactive employee status, and military leave for active duty) only if you continue to pay your monthly cost for the coverage.

Dependents. Dental coverage for your dependent(s) ends (except as permitted under COBRA) on the earliest of the following:

The day your coverage ends.

The last day of the month in which your dependent is no longer eligible for coverage.

The first day of the month in which you no longer make contributions for dependent coverage.

The last day of the month for which the last required payment is made by the participant (as in COBRA).

The day on which the plan ends.

Coverage Continuation Provisions

Survivor Dental Benefits. If you die while covered under the dental plan, coverage for your covered dependents will continue until the earliest of the following:

Three months after the end of the month in which you die

The last day of the month in which your dependent(s) is no longer eligible for coverage

The last day of the month in which your dependent(s) becomes eligible for Medicare Part A

The first day of the month in which your dependent(s) no longer makes contributions for coverage

The day on which the plan ends.

Your dependents may be eligible to elect continued coverage under COBRA.

Your Benefits at Retirement. Once you retire, neither you nor your dependent(s) may continue in the ***Benefits by Design*** dental plan, except as provided under COBRA.

Conversion Privilege. You may not convert your dental coverage to an individual Delta Dental plan.

Continued Coverage (COBRA)

If you or your dependent(s) become ineligible for coverage under the ***Benefits by Design*** dental plan, continued coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) may be available if you (or your dependents) enroll and pay the applicable costs. Except in cases where coverage is extended due to disability, your cost for this coverage is 102% of the full cost of coverage.

Eligibility for Continued Coverage. To be eligible for continued coverage (COBRA), you or your dependent(s) must be covered under the ***Benefits by Design*** dental plan immediately before you request continued coverage. You may elect to continue the same dental plan you enjoy as an active employee. (However, you will not pay the same contribution you paid as an active employee.)

You and your covered dependent(s) may continue coverage through COBRA when regular coverage ends due to one of the following events:

Your full-time employment ends

Your employment status changes from regular full-time to temporary or part-time.

Continued coverage is also available to your covered dependents when their regular coverage ends due to one of the following events:

You die

You become divorced or legally separated

Your dependent ceases to be eligible for coverage

You become eligible for or entitled to Medicare Part A benefits.

Duration of Continued Coverage. Continued coverage for you and your eligible dependents may extend for up to **18 months** after you end full-time employment or your employment status changes.

Continued coverage for your dependents may extend for up to **36 months** after your death, divorce, legal separation, or eligibility for Medicare. Additionally, your dependents may continue their coverage for 36 months if they become ineligible for coverage.

Coverage may end sooner than the times specified above if one of the following events occurs:

The cost for a covered individual is not paid within 30 days following the first of the month for which the payment is due. (For example, if the payment for January is not paid by January 31.)

The covered person becomes eligible, while on COBRA, for Medicare benefits or becomes covered under another group health plan (unless the plan does not cover a pre-existing condition of the covered person)

The ***Benefits by Design*** plan ends.

If You Are Disabled. Generally, if you or a covered dependent is disabled, the disabled person will be eligible for continued coverage for up to 18 months, whether or not he or she meets the Social Security Administration's definition of "disabled."

Continued coverage may be extended **after** 18 months if you or your dependent is disabled as defined by Social Security either on the date your employment ended (or within 60 days thereafter) or, alternatively, on the effective date of an employment status change that makes you and your dependents eligible for continued coverage.

Under these circumstances, the disabled person will be eligible to continue coverage for up to 11 additional months (up to 29 months **total**). Non-disabled dependents (of the disabled person) who are entitled to COBRA coverage are also eligible for the 11-month extension of coverage. To elect an extension of dental coverage for a person who is determined to be disabled under Social Security, you must notify the Benefits Office by the earlier of (1) 60 days after the person is declared disabled, or (2) the last day of the initial 18-month coverage continuation period. The cost of coverage for the additional 11 months will be 150%, rather than 102%, of the full cost of coverage.

Continued coverage for disability may end sooner than 29 months if you or your dependent is no longer considered disabled by Social Security. Coverage for non-disabled dependents would end if your own coverage were to terminate before the end of 29 months.

Election Period/Notification. You have a certain period of time in which to elect continued coverage, as described below. If you do not elect continued coverage during this period, or if you give up your right to continued coverage, your decision is considered final. **You will not have another opportunity to elect continued coverage.**

The company will notify you, or your dependent(s) if applicable, of the right to continue coverage under COBRA as soon as the company is aware that regular coverage will end because you end active employment, retire, become eligible for Medicare benefits, change your employment status, or die. You or your dependent(s) have 60 days from that notification or the date of the event (whichever is **later**) to elect continued coverage.

You or your covered dependent(s) must notify the Benefits Office within 60 days if eligibility ends due to divorce or your dependent child losing eligibility. The company will then notify you or your dependent(s) of the right to continue coverage. You or your dependents have 60 days from notification by the company to elect continued coverage.

Paying for Continued Coverage. If you or your dependents elect continued coverage, the cost of at least the first month of coverage must be paid within 45 days after you elect continued coverage. You will be charged from the date you become eligible for continued coverage, regardless of when you elected the coverage during the election period. To ensure timely reporting of eligibility and avoid delay in processing your claims, you should remit the contribution amount before the first of the month for which the payment is being made. Your coverage will be terminated without notice if the Benefits Office does not receive your payment within 30 days after the first of the month for which the payment is due.

Payment of Claims. If you or your dependent(s) elect to continue coverage when it is first offered, claims will be payable from the effective date of coverage. However, claims cannot be processed unless you have paid the cost of coverage.

If you or your eligible dependents **do not** elect to continue coverage (COBRA), the ***Benefits by Design*** plan will not pay benefits for expenses you or your dependents have after the date your coverage ends. This applies **even if** the condition being treated began while you or your dependents were covered by the plan.

Definitions

Company means Bechtel BWXT Idaho, LLC.

Disabled (totally) means you are not able to perform any of the usual and customary duties of any occupation. For dependents, this means your dependent cannot perform any of the usual and customary duties or activities of a person in good health and of the same age.

Employee means a regular full-time employee of the company, excluding in all cases, part-time and temporary employees.

Medically necessary services include any confinement, treatment, service or supply that is prescribed by a dentist legally licensed to practice medicine and surgery and considered by Delta Dental or an independent review panel to be:

Necessary, appropriate, and consistent with the diagnosis according to national acceptable standards of practice

Nonexperimental or noninvestigational.

Usual, Customary, and Reasonable (UCR) fees are defined as follows:

For Delta Dentists, the UCR fee for any single procedure is the fee which the Dentist has filed with Delta and which Delta has accepted as follows:

- A usual fee is the amount which a Dentist regularly charges and receives for a given service. If a Dentist charges more than one fee for a given service, the "usual" fee for that service is the lowest fee which the Dentist regularly charges or offers to patients.

- A fee is customary when it is within the range of usual fees charged and received for a particular service by Dentists of similar training in the same geographic area which Delta determines is statistically relevant.

- A fee is reasonable if it is "usual" and "customary," or if Delta agrees that a fee that falls above customary is justified by a superior level of care or by the extraordinary circumstances of the case in question.

For a non-participating Dentist, his or her "usual, customary, and reasonable" fee is presumed to be the "prevailing fee" for that procedure. The "prevailing fee" is the fee for a single procedure which satisfies the majority of Dentists in Idaho, as determined by Delta based upon confidential fee listings accepted by Delta from participating Dentists.

Vision Care Plan

Introduction

Benefits by Design offers a vision care plan to help you pay for eyeglass frames and lenses, contact lenses, and eye exams. The Vision Plan is insured and administered by Vision Service Plan (VSP). VSP makes all decisions regarding covered services and benefits payable under this plan.

Participation in the vision plan is a 2-year election. Although you may receive your vision care from the ophthalmologist, optometrist, or optician of your choice and still receive plan benefits, you will receive a **higher level of benefits** from the plan if you obtain these services from the selected providers who are part of the VSP network. You may obtain a list of the VSP providers from the Benefits Office or by calling Vision Service Plan at 1-800-877-7195. Additionally, you may access this information through the direct link from the Benefits Homepage to the VSP website.

Vision Plan Costs

Contributions for vision care insurance are withheld from your paycheck on a pre-tax basis. Your cost depends on the coverage you choose (employee only, employee and family, employee and children, or employee and spouse). The company does not provide credits for vision coverage; you pay the entire cost.

Vision Plan Benefits

Summary. The following table summarizes your vision benefits:

Plan Features	Services from a VSP Participating Provider	Services from a Non-Participating Provider
Annual Deductible (per person)	$35	$35
Examination—every calendar year	Paid-in-Full*	up to $ 40.00
Single Vision Lenses—every calendar year	Paid-in-Full*	up to $ 40.00
Bifocal Lenses—every calendar year	Paid-in-Full*	up to $ 60.00
Trifocal Lenses—every calendar year	Paid-in-Full*	up to $ 80.00
Lenticular Lenses—every calendar year	Paid-in-Full*	up to $125.00
Frames—every two calendar years**	A wide selection of attractive frames are covered in full. *Retail prices are not applicable as frame coverage is based on wholesale pricing**	up to $ 45.00
Contact Lenses *(Instead of spectacle lenses and frame)*		
Medically Necessary	Paid-in-Full*	up to $210.00
Elective	up to $105.00	up to $105.00

*Subject to plan definitions and/or limits.
**Frames allowed every 2 years, provided contact lenses not purchased in intervening year.

Elective Contact Lenses. A standard eye examination is covered in full, less a $35 deductible. An additional allowance of $105 is provided for contact lens evaluation examination, fitting costs, and materials. Any costs exceeding this allowance are your responsibility.

Medically Necessary Contact Lenses. Contact lenses that are considered medically necessary by VSP will be covered in full when prescribed by a VSP member doctor in the following situations:

- Following cataract surgery
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
- For certain conditions of anisometropia
- For certain conditions of keratoconus.

Optional "Extras". The Vision Plan is designed to cover your visual needs only. You will be charged additional amounts if you choose "cosmetic" eyewear features such as:

- Blended lenses
- Contact lenses (except as noted elsewhere herein)
- Oversized lenses
- Progressive multifocal lenses
- Coated or laminated lenses
- Frames that cost more than plan allowances
- Certain low vision care options
- Cosmetic lenses
- Optional cosmetic processes
- UV protected lenses.

Frames Availability. Frames are generally available once every two calendar years. However, if you purchase contact lenses in a year instead of spectacle frames and/or lenses, you will not be

eligible for a frame until the second calendar year (from the year when you purchased the contact lenses).

Example

Suppose you purchase eyewear every year. The following charts show the benefits payable from the plan each year. The shaded portion indicates the choice made. (You will have the same choices with or without a VSP provider).

1999 **You may receive…**		
An eye exam and spectacle lenses and a frame	or	An eye exam and elective contact lenses

2000 **You may receive…**		
An eye exam and spectacle lenses*	or	An eye exam and elective contact lenses**

* After purchasing a frame in 1999, you are not eligible for a frame again until 2001.

** After purchasing contact lenses in 2000, you are not eligible for a frame until 2002. And, if you select contact lenses again in 2001, a frame isn't an option again until 2003.

2001 **You may receive…**		
An eye exam and spectacle lenses	or	An eye exam and elective contact lenses

Low Vision Benefit. A low vision benefit is available to covered persons who have several visual problems that are not correctable with regular lenses. This benefit is subject to prior approval by a VSP consultant. Call 1-800-877-7195 for more information.

Special Features

- Additional Glasses–The VSP plan provides 100% coverage for one pair of glasses (subject to established plan maximums) each calendar year. Additional pairs of glasses may be obtained within the calendar year from your VSP member doctor at a discounted rate.

- Contact Lenses–The VSP plan provides a benefit of up to $105 for elective contact lenses each calendar year. Participants who use their annual VSP benefit to purchase contact lenses may purchase additional contact lenses (including replacement and disposable lenses) from a VSP member doctor and receive a discounted rate. Participating employees may also take advantage of the VSP discounts to purchase contact lenses in a year when they have used their regular VSP benefit to purchase glasses.

The VSP discounts for additional pairs of glasses and elective contact lenses are available on an unlimited basis for 12 months following the date of the participant's covered eye exam by a member doctor.

Vision Expenses Not Covered

The vision services and supplies **not covered** under the plan include, but are not limited to, the following:

- Orthoptics or vision training and any associated supplemental testing

- Plano lenses (nonprescription)

- Two pair of glasses in lieu of bifocals

- Replacement of lost/broken lenses and frames furnished under this program except at the normal intervals when services are otherwise available

- Medical or surgical treatment of the eyes

- Any eye examination, or any corrective eye wear, required by an employer as a condition of employment

- Experimental treatments

- "Extra cost" items as described above under "Optional Extras."

Filing Claims

Filing claims for vision services is easy if you use a VSP member doctor.

Step One: Select the doctor of your choice and make an appointment. Remember to identify yourself as a participant in BBWI's VSP plan.

Step Two: When your eye examination has been completed, the doctor will have you sign the front of a VSP benefit form that he/she will obtain on your behalf. In addition to the $35 deductible, the doctor will itemize any cosmetic options that are your responsibility. A copy of the benefit form will be provided for your records.

Step Three: VSP pays the Member Doctor directly according to their agreement with the doctor. Selecting a doctor from the VSP list assures direct payment to the doctor and provides a guarantee of quality and cost control.

What if you don't use a VSP Member Doctor? Over 90% of VSP patients receive services from member doctors. However, you may obtain covered services or materials from any other licensed optometrist, ophthalmologist, or optician of your choice. In these situations you may obtain a VSP benefit claim form by calling VSP at 800-622-7444. After paying the non-member provider in full for the services you obtain, you may submit your form and an itemized receipt to VSP at the following address:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

VSP will reimburse you up to the amounts allowed under the plan's nonmember provider schedule. **Please note that the nonmember reimbursement schedule does not guarantee full payment. Additionally, VSP cannot guarantee patient satisfaction when services are received from a nonmember provider.**

All claims must be filed within 6 months of the date when services are completed. Reimbursement benefits for services obtained from nonmember providers are made directly to you and are not assignable to the provider.

When Coverage Ends

Vision coverage for you and your eligible dependents ends according to the same provisions described under the dental plan.

Your Benefits at Retirement

Once you retire, neither you nor your dependent(s) may continue in the vision plan, except as provided under COBRA.

Continued Coverage (COBRA)

If you or your dependent(s) become ineligible for coverage under the vision plan, continued coverage, as provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA), may be available according to the same provisions described under the dental plan.

Definitions

Company means Bechtel BWXT Idaho, LLC.

Disabled (totally) means you are not able to perform any of the usual and customary duties of any occupation. For dependents, this means your dependent cannot perform any of the usual and customary duties or activities of a person in good health and of the same age.

Employee means a regular full-time employee of the company, excluding in all cases, part-time and temporary employees.

Flexible Spending Account Plan

Introduction

The Health Care and Dependent Day Care Flexible Spending Accounts allow you to pay for eligible health care and dependent day care expenses using **tax-free** dollars. This generally reduces your out-of-pocket cost for these services.

The Flexible Spending Account Program is administered by Aetna.

Summary of Flexible Spending Accounts (FSAs)

If you routinely have health care or dependent day care expenses, the FSA program will allow you to use a portion of your pre-tax compensation to pay for such expenses. The risks associated with this program are described below under "Risks Associated with FSA's."

Flexible spending accounts (FSAs) for health care and dependent day care expenses are allowed under Section 125 of the Internal Revenue Code (IRC). Section 125 allows you to authorize a specific pre-tax dollar amount to be "redirected" from your pay, without having federal (and, in most cases, state) income and Social Security taxes withheld. "Redirected" means the company reduces your taxable pay by the amount you authorize and places that amount in your spending account. The pre-tax dollars you contribute to your spending account may then be used to reimburse yourself for eligible health and dependent day care expenses, without tax consequences, for one plan year (January 1 through December 31).

Participation in the FSA program is strictly voluntary. You may contribute to one, both, or neither of these accounts.

Because the Health Care Spending Account and the Dependent Day Care Spending Account are separate accounts, you contribute to them separately. You may not transfer money between the accounts and you may not use money in one account to pay expenses related to the other account.

Maximum Contribution Amounts

The most you may contribute to your Health Care Spending Account is $166.66 a month, for a maximum contribution of $2,000 per calendar year (also the same as plan year). The most you can contribute to a Dependent Day Care Spending Account is $416.66 a month ($5,000 a year), or $208.33 ($2,500 a year) each if you and your spouse file separate income tax returns. The Internal Revenue Code places some additional limits on the amount you may contribute to your Dependent Day Care Spending Account as follows:

Your total Dependent Day Care Spending Account deposits for the year can be no more than your income, or your spouse's income, whichever is less.

For any month your spouse is a full-time student or seriously disabled, account calculations may be made as if your spouse earns an income of $200 per month if you have one qualifying dependent in your home, or $400 per month if you have two or more qualifying dependents in your home.

If your spouse has a similar before-tax spending account for day care expenses through his or her employer, the combined total the two of you may contribute to your Dependent Day Care Spending Accounts is $5,000 per year.

Divorced employees must generally have custody of their dependent children to contribute to a Dependent Day Care Spending Account. Please refer specific questions to your tax advisor.

If you decide to participate in the FSA program, the amount you elect to contribute will be taken in 24 equal payroll deductions during the calendar year. Please note that your contribution election may be subject to adjustment in order for the program as a whole to remain in compliance with the IRC and Treasury Regulations, especially those provisions that ensure the plan does not discriminate in favor of highly paid employees.

Full-time employees hired after the annual enrollment period, and employees who have a qualified family status change during the calendar year, may contribute a maximum of $166.66 per month to a Health Care Spending Account, or $416.66/$208.33 per month (as applicable) to a Dependent Day Care Spending Account, for the remainder of that plan year.

Eligible Expenses for Health Care Spending Account

You can use your Health Care Spending Account to pay for medical, dental, vision and other health-related expenses (for you and/or your IRS dependents) that are not covered under the ***Benefits by Design*** plans (or your spouse's plans, if you are married). Generally, any medical or dental expense that is tax deductible, and results from services/supplies received by you and your dependents during the plan year while you are a plan participant, is eligible for reimbursement from your Health Care Spending Account.

Some examples of eligible expenses include:

Your percentage of the cost of covered services (such as your 20% or 30% copayment amount).

Your medical, dental, and vision plan deductibles.

The out-of-pocket cost for eye exams, eyeglasses, and contact lenses.

Your medical expenses that exceed the reasonable and customary (R&C) charges.

The cost of hearing aids and hearing exams.

Your $10 or $15 copayment for the mail order prescription drug program, and your 20% or 30% copayment for the retail prescription drug program.

The cost of orthodontic services. Please note that reimbursement of orthodontic services is generally based on date of service, not on date of payment. When a lump sum payment is made for all or a portion of such services, a receipt of payment will be required in addition to a bill in support of the lump sum amount paid.

The cost of chiropractic services.

For the complete list of all eligible, tax-deductible health care expenses, refer to IRC Section 213 (Health Care Expenses), IRS Publication 502 (Medical and Dental Expenses), or contact your personal tax advisor.

Eligible Expenses for Dependent Day Care Spending Account

You can use your Dependent Day Care Spending Account to pay day care expenses for your eligible dependents so you and your spouse can work. Eligible dependents include: (a) your children age 12 and under who live with you and whom you claim as dependents on your tax return, (b) older children who are mentally or physically incapable of self-care and depend on you for support, or (c) a disabled parent or spouse who lives with you and requires care while you work.

Generally, any dependent day care expense that is eligible for an income tax credit and is incurred during the plan year is eligible for reimbursement from your Dependent Day Care Account.

Expenses eligible for reimbursement include those for dependent day care in your home, in a neighbor's home (with less than six children in day care at the home), at a licensed day care facility, or by a relative who is not your dependent.

For a complete list of all eligible child and dependent day care expenses and eligible dependent day care providers, refer to IRC Section 129 (Child and Dependent Day Care Expenses), IRS Publication 503 (Dependent Day Care Expenses), or contact your personal tax advisor.

Filing Claims

General Information. To be reimbursed from your spending account(s) for eligible health care and dependent day care expenses, you must provide either a receipt, written statement, or an explanation of benefits.

You may submit a claim for reimbursement from your spending account(s) any time; however, reimbursements of less than $50 will be held and processed the following month. At the end of the year, the $50 minimum is waived. Claims are processed once each month.

Claim forms for your Health Care and Dependent Day Care Spending Accounts are available from the Benefits Office. Be sure to complete all parts of the claim form and attach all supporting information before you submit your claim. Send your completed claim form to:

Aetna
P.O. Box 578850
Oklahoma City, OK 73157-8850

The monthly cutoff for processing reimbursement claims is the last business day of the month. Reimbursement requests received by the last business day of the month will be processed on the 12th of the following month, and you should receive your reimbursement check by the 15th. If your reimbursement request is received **after** the last business day of the month, the processing of your check will be delayed a month.

The toll free number to use if you have questions about your reimbursement claim is:

1-877-801-0825.

Health Care Claims. Employees who participate in a health care FSA may file their reimbursement claims in two ways.

1. **Streamlined Automatic Submission**–With the streamlined submission process, employees make an election at the beginning of the plan year to have all their eligible health care expenses automatically applied to their Health Care FSA. This process then becomes effective for all medical claims that are submitted to Aetna during that plan year, including those that are filed directly by providers as well as those that are filed by the employee. (Please note that streamlined processing is **not** available for dental, vision, mental health, and/or prescription drug claims.) With this option, *no separate claim submission is needed for FSA reimbursement of qualified expenses that are initially filed with Aetna under the **Benefits by Design** medical plan.*

   Please be aware that the streamlined submission process will not work for everyone. In particular, if your spouse works and has other medical overage in addition to being covered

as a dependent under your own medical plan coverage, you may not elect the streamlined automatic submission process for your health care FSA reimbursement claims.

2. **Separate Submission**–Employees who choose the separate submission process must first submit any covered medical expenses to Aetna for reimbursement under the medical plan. The resulting Explanation of Benefits form (or other proof of expenditure for expenses that are not reimbursed under the medical plan) is then submitted to Aetna using a separate FSA reimbursement claim form.

With a Health Care Spending Account, you will be reimbursed for the total amount of your claim, up to the annual maximum you choose to contribute less any previous reimbursements. **This applies even if you have not yet contributed enough money to your account to cover the amount of your claim.**

Dependent Day Care Claims. Claims for reimbursement of dependent day care expenses may be sent directly to Aetna, together with copies of your receipts or a written statement showing the dates of service, the person or organization providing the service, the address of the provider, and the amount of the expense. If the day care is provided by an organization or center, you must include the Federal Taxpayer Identification number. If the day care is provided by an individual, you must include his/her Social Security number.

Reimbursement of dependent day care expenses is limited to the balance in your account at the time the claim is made. If you have not yet contributed enough to your Dependent Day Care Spending Account to cover your claim in full, you will be reimbursed only up to the balance in your account. Any amount above your current account balance will be paid as you contribute more money to your account.

Risk Associated With FSAs

While the Flexible Spending Account Program offers advantages, there are also risks associated with FSAs. If, by the end of the year, you do not incur the expenses you had anticipated and you have money left in your account, you will lose the unspent balance. Therefore, you should only redirect enough of your pay to cover the eligible expenses that you are sure you will have. As provided by federal law, all forfeited dollar amounts will be used by the company to offset the administrative costs for the program.

Annual Filing Deadline

You may submit claims for reimbursement of qualified health care and dependent day care expenses until March 31 of the following year. Reimbursement requests and any needed supplemental information must be received at AETNA by March 31 of the following year. For example, eligible expenses incurred in 1999 can be submitted for reimbursement until March 31, 2000. Eligible expenses incurred in 1998 or 2000 cannot be paid from your 1999 account.

Coordinating FSA Savings With Income Tax Deductions

Health Care Expenses. The Internal Revenue Code allows you to save taxes on out-of-pocket medical costs in two ways:

You can pay all eligible health care expenses through your spending account(s) with before-tax dollars, up to the annual contribution limits

You can take an itemized deduction for health care expenses on your federal income tax return to the extent that these expenses are greater than 7.5% of your adjusted gross income.

Please note that you **cannot** pay expenses through your spending accounts *and* take the itemized deduction for the *same expenses*. Although the method that creates the most savings for you depends on your personal situation, generally, it will be more advantageous to use your Health Care Spending Account to pay for qualified health care expenses. This is because **all** expenses can be reimbursed from your FSA account, not just those over 7.5% of your adjusted gross income. In addition, you won't have Social Security taxes withheld from money you contribute to a Health Care Spending Account.

Note: This summary should not be read as legal or tax advice. Please consult your tax advisor for details regarding how participation in this program will affect your particular situation.

Dependent Day Care Expenses. The IRS allows you to save tax dollars on dependent day care expenses as follows:

You can pay all eligible dependent day care expenses through your FSA account with before-tax dollars (up to the annual contribution limit)

You can take a tax credit on your federal income tax return for dependent day care expenses.

Federal Tax Credit. The maximum expenses allowable for tax credit purposes are $2,400 for one qualifying dependent and $4,800 for two or more dependents. However, only a percentage of these expenses may be claimed as a tax credit. The credit is between 20% and 30% of your dependent day care expenses and depends on your adjusted gross income, as shown below:

Adjusted Gross Income	Tax Credit Percentage
$28,001 and above	20%
$26,001–$28,000	21%
$24,001–$26,000	22%
$22,001–$24,000	23%
$20,001–$22,000	24%

$18,001–$20,000	25%
$16,001–$18,000	26%
$14,001–$16,000	27%
$12,001–$14,000	28%
$10,001–$12,000	29%
$10,000 or less	30%

Expenses reimbursed through your Dependent Day Care Spending Account reduce dollar-for-dollar the amount of expenses allowable in determining your federal tax credit. For example:

	One Dependent	**Two Dependents**
Maximum allowable expenses for tax credit	$2,400	$4,800
Dependent Day Care Account	–$2,000	–$4,000
Remaining allowable expenses for federal tax credit	$400	$800

Depending on your personal situation, one approach may give you a greater tax break than the other. As a general rule, if the total adjusted gross income for your household is more than $24,000 or less than $15,000 you may save taxes by using the Dependent Day Care Spending Account. However, if your household income is between $15,000 and $24,000, the tax credit may be more advantageous for you.

Because tax laws are complicated and change from time to time, it is a good idea to consult your tax advisor to find out which approach is best for you.

Family Status Changes

Once you have elected the before-tax dollar amount you want to contribute to your account(s) during the year, you cannot change that amount unless you have a **qualified family status change and the change is consistent with the qualified family status change**. A qualified family status change includes:

Your marriage or divorce

The birth or adoption of your child

The death of your spouse or child

Your dependent’s ceasing to be eligible for coverage

Your or your spouse's change in employment status

A significant change in the health care coverage or cost (for you or your spouse) under your spouse's health care plan (unless your spouse participates in the ***Benefits by Design*** program)

The finalization of a Qualified Medical Child Support Order.

If you have a qualified family status change, you may change your spending account contribution amount as long as the change is consistent with the change in your family status. To take advantage of this provision, you must notify the Benefits Office in writing within 30 days of the qualified family status change, and complete the necessary paperwork generally within 60 days.

When Your Participation Ends

Your participation in the FSA program is on a calendar year basis. If you wish to participate in this program, you must make a new enrollment each year during the annual enrollment period.

If your employment ends during the calendar year, your pre-tax contributions to your account(s) stop. You may only be reimbursed for those qualified expenses incurred through the last month of your coverage as a BBWI employee (unless you elect the after-tax contribution provision available with the COBRA continuation provision as described below). You will have 90 days from the end of the calendar year in which your employment ends to file a request for reimbursement from your account(s) for expenses incurred prior to the end of your employment. **You will forfeit any amounts remaining in your account after the deadline for filing claims.**

If you die, your contributions to your account(s) stop. However, your spouse or dependent may continue to submit claims for eligible expenses (incurred up to the last day of the month in which you die) until 90 days after the end of the plan year in which you participated in the account(s).

Continuing Your Contributions Through COBRA

If your participation in the spending accounts ends because your employment ends (other than for reasons of gross misconduct) or because your work hours are reduced, you may continue to make monthly contributions to your **Health Care Account** on an after-tax basis for up to 18 months.

If you elect to continue your health care coverage through COBRA, in certain circumstances your spouse or dependent child may also have the right to make monthly contributions to the Health Care Spending Account for up to 36 months. Contact the Benefits Office for additional information.

Effect on Social Security Benefits

Since you do not pay any Social Security taxes on the money you contribute to your spending account(s), you could reduce your future Social Security benefits by participating in this program. For most employees, this benefit reduction would be quite small and would be partially offset with current tax savings. Please consult your tax advisor to fully understand how participation in this program will affect your particular situation.

Life Insurance Benefits

Introduction

Life Insurance can provide valuable financial protection for you and your family in the event of your death or the death of a family member. The ***Benefits by Design*** Program offers six choices of life insurance for you. You can also purchase life insurance for your dependent spouse and children. All life insurance premiums are paid on an after-tax basis.

Summary of Life Insurance Coverage

The company provides enough credits for you to purchase regular group term life insurance equal to 2.25 times your base annual salary at no out-of-pocket cost. Coverage that you purchase in excess of 2.25 times your base annual salary is Group Universal Life (GUL) insurance. (Please note that your excess coverage may not be GUL insurance if you were disabled on January 1, 1998. See the discussion under "Employees Who Were Disabled on January 1, 1998" later in this section.) The various options for employee life insurance are shown below:

Option	Term Insurance	GUL Insurance	Total Coverage
1	Lesser of $50,000 or 2.25 times salary	Excess (if any) of $50,000 over 2.25 times salary	$50,000
2	1 times salary	N/A	1 times salary
3	2.25 times salary	N/A	2.25 times salary
4	2.25 times salary	1 times salary	3.25 times salary
5	2.25 times salary	2 times salary	4.25 times salary
6	2.25 times salary	3 times salary	5.25 times salary

The salary amount used in these computations is your "base annual salary." Base annual salary is the amount you are paid for performing the duties required of your job; it does not include bonuses, overtime pay or similar payments. For salaried employees, "base annual salary" is your regular base annual salary rate (regular base monthly salary rate multiplied by 12). For hourly employees, "base annual salary" is your base hourly rate multiplied by 2,080 hours, unless otherwise stipulated by a current bargaining unit agreement. The amount of your life insurance coverage changes automatically effective the first of the month following a change in your salary, provided you are actively at work.

The maximum coverage available through this program is $1,000,000, of which no more than $500,000 may be term insurance provided by the company, and no more than $500,000 may be GUL insurance.

Employees Who Were Disabled on January 1, 1998

Employees who were disabled on January 1, 1998, and who subsequently returned to work, are able to participate in GUL insurance just as employees who were not disabled on January 1, 1998. GUL coverage for these employees was effective on the date they returned to work, in an amount equal to the excess of total insurance purchased over 2.25 times salary.

Employees who were disabled on January 1, 1998 and who **did not** subsequently return to work are not able to participate in GUL insurance. All of the life insurance continued for these employees, both company-provided coverage and any amount in excess of the company provided coverage, is group term life insurance. The provisions of GUL insurance described later in this section do not apply to any portion of the life insurance continued by these individuals.

Proof of Good Health Requirements

If you enroll in life insurance when you are first eligible to participate, you will be able to choose any level of coverage ***except 5.25 times your base annual salary*** without providing proof of good health. Employees who initially enroll for coverage equal to 5.25 times their base annual salary will be required to provide proof of good health. In this situation, coverage will be limited to 4.25 times base annual salary until the Benefits Office is notified that the proof of good health has been reviewed and approved by the insurance company. Coverage will be increased to 5.25 times base annual salary effective the first of the month following this notification.

If you enroll in life insurance when you are first eligible to participate, and choose to increase your level of coverage at a later date, you will be required to provide acceptable proof of good health before the higher coverage will be effective. For example, proof of good health will be required if you enroll initially for coverage equal to 2.25 times your base annual salary and later wish to increase your coverage to 3.25 times your base annual salary. In this situation, your

coverage will remain at 2.25 times your base annual salary until the Benefits Office is notified that the proof of good health has been reviewed and approved by the insurance company. Coverage will be increased to 3.25 times base annual salary effective the first of the month following this notification.

If you do not enroll in life insurance when you are first eligible to participate, you will be required to provide acceptable proof of good health to enter the plan at a later date (even for the lowest level of coverage). Your coverage will not be effective until the first of the month following the month in which the Benefits Office receives notification that your proof of good health has been reviewed and approved by the insurance company.

Cost of Coverage

The company provides you with enough credits to purchase term life insurance equal to 2.25 times your base annual salary at no out-of-pocket cost. If you choose life insurance coverage that is less than 2.25 times your salary, you have excess credits that can be spent in other benefit areas. If you participate in the GUL program and choose life insurance coverage that exceeds 2.25 times your salary, you pay for the additional coverage with after-tax dollars using age-rated premiums shown below:

Age	Monthly Cost per $1,000 (1999)*
<30	$0.047
30–34	$0.056
35–39	$0.078
40–44	$0.112
45–49	$0.232
50–54	$0.390
55–59	$0.698
60–64	$0.966
65–69	$1.737
70 +	$3.092

* Premiums are subject to change each year.

The cost of life insurance increases automatically when you move into a new age-rated premium bracket, effective the first of the month following your birth date.

Using age-rated premiums reduces the imputed income you must recognize on group term life insurance amounts in excess of $50,000 (see “Taxes on Life Insurance”). Employees who

choose term life insurance coverage equal to or less than $50,000 are able to avoid imputed income altogether. Please note that GUL insurance is not subject to the imputed income rules that apply to regular group term life insurance. Employees who are eligible for GUL coverage (see limitations described earlier in "Employees who Were Disabled on January 1, 1998") and who purchase life insurance in excess of 2.25 times their base annual salary are not liable for imputed income tax on such excess coverage. (This is because all coverage over 2.25 times base annual salary is GUL insurance.)

All premiums for life insurance are paid on an after-tax basis.

Changes in Coverage Amounts

When your salary changes, your life insurance coverage amount will change automatically. Your new coverage amount will generally become effective on the first day of the month following your salary change. You must be at work full-time on the effective date of any change in the amount of your insurance; otherwise, the change will become effective on the day you return to active full-time work.

You may **not** change your coverage amount during the year, even if you have a qualified change in family status. However, you may change your coverage amount during the annual ***Benefits by Design*** enrollment period.

Satisfactory proof of good health must be submitted for all increases in total life insurance coverage. Coverage at the higher level will not be effective until the first of the month following the month in which the Benefits Office is notified that the required proof of good health has been reviewed and approved by the insurance company.

Special Features of Group Universal Life Insurance

All company-provided insurance is regular group term life insurance. As explained earlier, all insurance that employees purchase in excess of the company-provided amount is Group Universal Life (GUL) Insurance. ***The information that follows applies only to any GUL insurance you may purchase.***

GUL Living Benefit. If you are diagnosed with a terminal illness and are not expected to live longer than six months, you may request a Living Benefit. Under this provision you may choose to receive, while you are still living, the following amount:

(1) Up to 50% of your coverage amount (not in excess of $250,000), plus

(2) A portion of your Cash Accumulation Fund Amount. The amount of your Fund Amount that is available under this option is equal to the percentage of total coverage elected under (1) above, times:

- Your total Fund Amount, less

- The amount of any outstanding loans and related interest.

When you die, your beneficiary will receive your coverage amount, minus the Living Benefit amount you received.

Effect on Other Benefits. Election of the Living Benefit option may affect other benefits or entitlements for which a person may be eligible, as well as his/her income tax liability, as follows:

If a person elects this option, the GUL insurance proceeds payable at death will be reduced.

Any payment made under this option may be taxable. You are advised to seek the help of a professional tax advisor for assistance with any questions you may have.

Election of this option may effect eligibility for Medicaid or other government programs. You are advised to seek the help of a professional legal advisor for assistance with any questions you may have.

Conditions. Eligibility for the Living Benefit option is subject to the following conditions:

A person may elect the Living Benefit option only once during the time he/she is covered under the plan.

An election under this provision must be made in writing.

There must be satisfactory proof, including written certification by a personal physician, that the person's life expectancy is six months or less.

The person's GUL coverage must not be assigned.

Since the Living Benefit is made available on a voluntary basis only, a person will not be eligible if:

- A law requires using this option to meet the claims of creditors, whether in bankruptcy or otherwise, or

- A governmental agency requires using this option in order to apply for, get, or keep a government benefit or entitlement.

Please be aware that once a person elects the Living Benefit option, he/she may no longer (1) increase the level of GUL coverage, (2) make a lump sum contribution to his/her optional cash accumulation fund, or (3) increase the amount of contributions to his/her optional cash accumulation fund.

Effect on GUL Coverage. When a person elects this option, the total amount of GUL insurance proceeds otherwise payable on the person's death will be reduced by the amount received as a Living Benefit. The amount received as a Living Benefit will also reduce any amount a person could otherwise have converted to an individual contract.

The insurance company reserves the right to make a distribution from a person's optional cash accumulation fund when benefits under this option are paid. Any such distribution will be made only to the extent needed to continue to qualify the GUL coverage as life insurance under the Internal Revenue Code.

Effect on GUL Contributions. When a person elects a Living Benefit, his/her monthly premiums will be adjusted based on the amount of GUL insurance remaining in effect.

GUL Optional Cash Accumulation Fund. Employees who purchase GUL insurance may contribute an additional amount of money to create a Cash Accumulation Fund. To participate, you must deposit at least $120 each year into the account. Contributions are conveniently deducted from your paycheck, or you can write a check to contribute a lump sum at any time. The interest rate will fluctuate from year to year, but is guaranteed to be at least four percent. Interest on your GUL optional cash accumulation fund is not taxable when earned.

Monthly Contributions. The minimum you can contribute to an optional cash accumulation fund is $10 per month or $120 per year. The insurance company will make a fund charge of $1 per month plus 2.25% of each such contribution. The balance of your contributions will remain in your fund, subject to the other provisions of GUL coverage.

You may change or stop your monthly contributions to an optional cash accumulation fund at any time. Contributions will not be allowed when you are no longer covered under GUL insurance.

Lump Sum Contributions. You may also contribute lump sum amounts toward your optional cash accumulation fund, subject to the following limitations:

You may not make lump sum contributions for an amount which would cause your fund to reach its limit.

You may not make a lump sum contribution for an amount less than $100.

Maximum Contribution Limit. There is an upper limit on the amount that may be contributed (for all contributions) each month. The maximum monthly contribution is determined based on factors that include age and previous contributions to the cash accumulation fund. You will be notified by the insurance company if your monthly contributions exceed this maximum.

To receive favorable tax treatment accorded to life insurance under federal law, GUL coverage must qualify under the Internal Revenue Code or successor law. To make sure the GUL

coverage qualifies, the insurance company reserves the right (1) to refuse contributions which would cause the GUL coverage to fail to qualify, and (2) to make changes in the GUL coverage or to make distributions from a person's optional cash accumulation fund to the extent needed to continue to qualify the coverage as life insurance.

Fund Activity – Balance. At any time, the amount of a person's optional cash accumulation fund is the net amount of:

Contributions, plus

Interest, minus

Monthly deductions, minus

Fund charges, minus

Any amounts that have been withdrawn.

Fund Activity – Contributions. Contributions include premiums paid for GUL coverage, as well as amounts you contribute to an optional cash accumulation fund.

Fund Activity – Interest. Interest determined by the insurance company at a rate not less than 4% per year will be credited on a person's optional cash accumulation fund. The insurance company will credit interest on a person's fund from the date it receives the contribution.

Fund Activity – Monthly Deductions. The Monthly Deduction is the amount required to provide your GUL coverage.

Fund Activity – Withdrawals. You may withdraw all or part of your fund by making a written request as follows:

Before November 1, 1999	On or After November 1, 1999
Kirke Van Orsdel (KVI)	Prudential
Attn: GT1	290 West Mount Pleasant Ave.
P.O. Box 9279	Livingston NJ 07039
Des Moines, Iowa 50306	

Please note that you may not withdraw that part of your fund equal to the balance of any loan (and related interest) you have made from the fund. If you do not wish to withdraw your entire account, the minimum you may withdraw is $200. The insurance company may not defer a withdrawal for more than six months.

Fund Activity – Loans. You may also take a loan from your optional cash accumulation fund. The most you may borrow is 90% of your fund balance, less one month's cost of GUL coverage.

The least you may borrow is $200. The insurance company may not defer a loan for more than six months.

You may take only one loan per calendar year from your fund, and can have only one loan in effect at any time. Interest will be charged daily at a yearly rate not to exceed 2% plus the rate of interest income credited to the fund. Interest is due when the loan is repaid (including partial repayments) or when the loan otherwise becomes due and payable. Interest not paid when due is added to the loan balance.

A loan and related interest will be due and payable from a person's fund:

When the person's face amount of insurance under GUL coverage ends, or

When the person dies, or

Any time the loan balance plus related interest equals the balance of the person's fund.

When the amount of a person's fund is reduced to zero because the loan balance plus interest equals the amount of the fund, the person's GUL coverage will continue until the date on which the insurance company would normally deduct the cost of monthly insurance coverage. If, on that date, the amount credited to the person's fund is less than the amount required for the monthly insurance coverage, the person's GUL coverage is in default. During the next sixty days (grace period), the insurance company will accept contributions and make the normal charges from the person's fund. However, if the monthly cost of insurance coverage is not paid by the end of the sixty day grace period, the person's GUL coverage will end at that time. The grace period is (1) 60 days, or (2) 30 days from the date the insurance company mails you a notice of default, whichever period is longer. (See below for how coverage may be reinstated following a default.)

You may pay back all or part of a loan at any time. Additionally, if you request, a loan may be canceled (or reduced by no more than $200) by deducting the amount needed from the fund from which it was borrowed. The only way to repay a loan is to make a lump sum payment or to deduct the amount owed from your fund.

The balance and related interest for any loan due at a person's death will be deducted from the death benefit to be paid.

A deduction from your fund (to repay any outstanding loan and related interest) will be made before paid-up insurance may be provided (as described below in "GUL Paid-Up Insurance").

Reinstatement of GUL Coverage Following Default. If a person's GUL coverage is still in default after the grace period ends (as described above in "Fund Activity-Loans"), it may be reinstated. To reinstate GUL coverage, the following conditions must be met:

The group contract must not have ended.

The person's optional cash accumulation fund must not have been used to purchase paid-up insurance.

The person must request reinstatement within 3 years from the end of the grace period.

The person must give satisfactory proof of good health to the insurance company.

The person must pay the amount, if any, needed to bring the person's fund balance to zero as of the date the GUL went into default.

The person must pay the monthly cost premiums through the end of the grace period.

The person must pay an amount which is sufficient to keep the GUL coverage in force for at least 2 months following reinstatement.

If approved by the insurance company, the reinstatement will become effective on the first day of the month coinciding with or next following the approval date.

GUL Paid-Up Insurance. When your GUL coverage ends, you may use your optional cash accumulation fund (if applicable) to pay the net single premium for paid-up insurance. If paid-up insurance is provided, all other benefits under GUL will end.

All of a person's optional cash accumulation fund, less the amount owed for any loan and related interest, may be used to purchase paid-up insurance subject to both of the following rules:

The minimum amount of a person's fund that may be applied to purchase paid-up insurance is $1,000.

The maximum amount of paid-up insurance that may be purchased is the amount of the person's death benefit just before the purchase.

Any amount of your fund which exceeds the amount used to provide paid-up insurance will be returned to you in cash.

All or part of a person's paid-up insurance may be surrendered for its cash value at any time. The insurance company may not defer a surrender of paid-up insurance for longer than six months. Paid-up insurance will not end when a person's insurance ends under other rules of the Group Contract. Unless surrendered, it will continue until the person's death.

The insurance company will determine that part of any dividend derived from a person's paid-up insurance. Such amount will be applied to increase the amount of the person's paid-up insurance, but will not be considered in determining the disposition or effect of dividends under any other provision of the Group Contract.

If you purchase paid-up insurance, your beneficiary designation (and changes thereto) must be filed with Prudential at:

The Prudential Insurance Company of America
290 West Mount Pleasant Avenue
Livingston, New Jersey 07039

GUL Coverage for Suicide. If a person, whether sane or insane, dies because of suicide, the death benefit under GUL insurance coverage may be limited, as follows:

If death because of suicide occurs within one year from the person's effective date of GUL coverage, the death benefit is limited to (1) the sum of contributions paid, less (2) any loan and related interest, less (3) any account charges, less (4) any amounts withdrawn from the person's fund.

If death because of suicide occurs within one year from the date of any increase in that person's GUL insurance coverage, the part of the death benefit that would be paid on account of that increase is limited to the sum of the premiums paid for that increase.

If death because of suicide occurs within one year from the date a person's GUL insurance coverage is reinstated, the death benefit is limited to (1) any contributions to an optional cash accumulation fund since the date of reinstatement, less (2) any loan and related interest, less (3) any amounts withdrawn from the person's fund.

Life Insurance for Employees Age 70½ or Older

If you are 70 1/2 or older and still employed by BBWI, you are required by law to start receiving your retirement benefits from the INEEL Employee Retirement Plan. When this happens, your GUL insurance coverage will not be affected. You will, however, have a choice to make at this time regarding your regular group term life insurance.

When you begin drawing retirement benefits from the INEEL Employee Retirement Plan, you will have a one-time election (which may not be revoked during the remainder of your active employment) regarding your regular group term life insurance as follows:

You may choose to retain the full amount of your regular group term life insurance through the remainder of your active employment. At the end of your active employment, you will be eligible to continue your insurance at a reduced level as described in the section "Life Insurance After You Retire."

You may choose to reduce your regular group term life insurance immediately (instead of waiting until your active employment terminates) as described in the section "Life Insurance After You Retire. Reduced coverage under this section could be continued at the same level at the end of your active employment.

Please contact the Benefits Office for further information about these two choices.

When Benefits Are Paid

Your company-paid life insurance benefit is paid if you die from any cause, at any time or place, while your INEEL insurance coverage is in effect.

The death benefit under GUL insurance will be limited in the event of suicide, as explained earlier in this section. The death benefit attributable to excess group term life insurance (over 2.25 times base salary) is also limited in the event of suicide for individuals who were disabled on January 1, 1998 and did not return to work. This coverage will not pay for loss of life due to suicide within one year of coverage.

Life insurance proceeds will be paid to your beneficiary(ies). You must designate your beneficiary in writing and file your designation form with the Benefits Office. You may change your beneficiary(ies) at any time by completing a new form and submitting it to the Benefits Office. (The only exception is for participants who purchase paid-up coverage under GUL. Beneficiary information for paid-up GUL insurance must be filed directly with Prudential.) If you designate more than one beneficiary but do not specify each beneficiary's share, the beneficiaries will share equally. If a beneficiary dies before you, his/her share will be shared equally by the remaining beneficiaries unless the beneficiary form states otherwise.

If you have not designated a beneficiary when you die, or if your beneficiary has also died, your regular group term life and your GUL insurance amounts will be paid to your surviving relative(s), in the following order:

Your spouse

Your children

Your parents

Your brothers and sisters

Your estate.

When Your Coverage Ends

Regular Group Term Life Insurance. Your regular group term life insurance coverage will end on the earliest of the following dates:

The end of the month in which your employment with the company ends

The end of the month in which you are no longer an eligible employee under the plan

The end of the month in which you are no longer eligible for coverage as an employee on Military Leave of Absence for Active Duty in the armed forces of any country, state or international organization

The end of the month in which you fail to pay your portion of the cost of life insurance (when applicable)

The date your employer no longer participates in the plan

The date the plan ends.

GUL Insurance. Your GUL insurance as a BBWI employee will end on the earliest of the following dates:

The end of the month in which your employment with the company ends.

The end of the month in which you are no longer an eligible employee under the plan.

The end of the month in which you no longer pay any contributions required to keep the insurance in force. If your insurance is in default, when you fail to pay the monthly deduction required to provide your GUL coverage during the grace period.

The date your employer no longer participates in the plan.

The date the plan ends.

Continuing GUL Coverage. Because GUL insurance is portable, you may be able to continue GUL coverage even after you cease to be eligible for employee coverage. If you leave the company or are no longer an eligible employee, or if you lose your coverage because your employer no longer participates in the plan (and does not offer a similar plan within 31 days), you may continue your GUL insurance — including your optional cash accumulation fund — beyond the date your coverage would normally have ended. Continuation of GUL insurance in these circumstances is subject to the following rules:

The effective date of continued coverage is the first day of the month after the insurance company receives notice that your GUL coverage would have ended.

The premiums required to keep the insurance in force will be different (higher) than the premiums you contributed as an employee. Contributions will not be withheld from your paycheck, but will be payable by you directly to the insurance company.

No increases in coverage will be allowed.

Continued coverage will end at the earlier of (1) the end of the group contract, or (2) your failure to pay, when due, any contribution that is required to keep your GUL insurance in force.

Additionally, you may be able to convert your GUL coverage to an individual life insurance contract as described under "Conversion Privilege."

When You Reach Age 100. When you reach age 100, you will have the following options regarding your GUL coverage:

You may elect to withdraw all of your fund.

You may continue your GUL coverage. If you elect this alternative, monthly deductions will no longer be required and the insurance company will no longer accept contributions other than to repay a loan. Your death benefit will be equal to your fund less the amount of any loan and related interest, less any past due payments for the cost of insurance.

Any additional provisions that may be a part of your GUL coverage will end.

If You Become Disabled

Regular Group Term Life Insurance. If you become totally disabled **before age 60** while you are covered under this plan, your regular group term life insurance coverage may remain in effect in accordance with the terms of the policy. The company will pay the cost of your life insurance coverage as long as you remain totally disabled.

GUL Insurance. If you are not retired and become totally disabled **before age 65** while you are covered under this plan, your GUL insurance coverage may remain in effect in accordance with the terms of the policy. Monthly premiums for your GUL coverage will be waived as long as you remain totally disabled.

Total Disability. "Totally disabled" under this plan means totally disabled (as determined by the insurance company) by injury or illness to the extent that you are unable to perform work for compensation or profit and are unable to engage in **any** business or occupation for which you are reasonably fitted by education, training, or experience.

For your life insurance coverage to remain in effect with the company paying the cost, you must:

Submit proof to the insurance company that you became totally disabled while covered under this plan and before you reached age 60 (or age 65 as applicable for GUL insurance)

Have been disabled for at least 6 consecutive months after your last day of active work.

You must submit the proof of disability no later than 12 months from the date of disability. You must continue to submit proof of disability each year you remain disabled for your life insurance coverage to continue. The insurance company may also require you to be examined by a physician at the insurance company's expense.

The company will no longer pay for your life insurance coverage, and your coverage will end, if one of the following events occurs:

You are no longer totally disabled (as determined by the insurance company)

You do not provide required proof that you are totally disabled

You do not agree to a medical examination, if required.

If your life insurance coverage ends and you do not return to active work with the company, you may convert your life insurance to an individual policy according to the "Conversion Privilege" provisions discussed below.

If you die while covered under the plan and **before you retire**, your beneficiary will receive one check for the amount of regular group term life insurance in effect on the date you became disabled, and a second check for the amount of GUL insurance in effect on that date. If you die while covered under the plan but **after you retire**, your beneficiary will receive the following amounts:

One check for regular group term life insurance in an amount as outlined in the section "Coverage When You Retire."

A second check for the amount of GUL insurance in effect on the date you became disabled.

Coverage When You Are on Leave of Absence

Layoff Status or Administrative Leave of Absence. If you are laid-off or take an Administrative Leave of Absence, you may continue your life insurance coverage as described below:

Regular Group Term Life Insurance. You may continue your regular group term life insurance for up to one year. To keep your coverage in effect, you must make all of the premium payments (including the company's cost) no later than the 20th of the month before the month for which you are continuing coverage. For example, your payment for June life insurance coverage would be due in the Benefits Office no later than May 20.

If your payment is not received by the 20th of the month before the month for which you want to continue coverage, your coverage will be canceled as of the last day of the month for which you paid your last premium. If you do not elect to continue your insurance while you are laid-off or on administrative leave, your life insurance coverage will end on the last day of the month in which you were laid-off or you began your administrative leave.

If your coverage ends and you return to active full-time work, your coverage can be reinstated on the day you return to work, provided you submit a completed application form (available from

the Benefits Office). If you do not complete an application form the day you return to work, you will be treated as a new employee for enrollment and coverage purposes.

GUL Insurance. You may continue your GUL insurance in accordance with the rules described earlier under "Continuing GUL Coverage." Premiums for GUL insurance during layoff or Administrative Leave of Absence should be made directly to KVI (before November 1, 1999) or Prudential (on or after November 1, 1999).

If you do not continue your GUL insurance coverage when your employment terminates due to layoff or Administrative Leave of Absence, and you resume employment with the company at a later date, you will be eligible for GUL coverage as a new employee on the date of your reemployment.

Military Leave for Active Duty. The following rules will apply if you are approved for Military Leave for Active Duty:

Regular Group Term Life Insurance. Your regular group term life insurance may be extended for up to one year while you are on Military Leave for Active Duty. Your coverage may be extended beyond one year, for up to two additional years, if you are not provided life insurance coverage through the military.

If your life insurance coverage remains in effect throughout your Military Leave for Active Duty, you will not have to re-enroll when you return to active full-time work at the end of your approved leave. If your life insurance does not remain in effect, your coverage can be reinstated on the date you return to full-time work if you submit an application form (available from the Benefits Office). If you do not complete an application form the day you return to work, you will be treated as a new employee for enrollment and coverage purposes.

GUL Insurance. You may continue your GUL insurance during Military Leave for Active Duty in accordance with the rules described earlier under "Continuing GUL Coverage." Premiums for GUL insurance while on Military Leave for Active Duty should be made directly to KVI (before November 1, 1999) or Prudential (on or after November 1, 1999). If you do not continue your GUL insurance coverage during Military Leave for Active Duty, and you resume employment with the company at a later date, you will be eligible for GUL coverage as a new employee on the date of your reemployment.

Family Medical Leave and Inactive Employee Status. Your regular group term life insurance and your GUL insurance may be continued during approved Family Medical Leave and Inactive Employee Status (IES) if you pay any required premiums to the Benefits Office in advance of each month's coverage. If premium payments are not received in advance, your insurance will be canceled as of the last day of the month for which your premium has been paid. If you return to active full-time work after your coverage has been canceled and you want to reapply for life insurance coverage, you must provide proof of good health. Coverage will not be effective until your proof of good health is reviewed and approved by the insurance company.

Taxes on Life Insurance

Under federal tax laws, you are allowed $50,000 of company-paid group term life insurance tax-free. If your company-paid group term life insurance coverage is more than $50,000, the value of the coverage over $50,000 is considered income for both federal income taxes and Social Security taxes. This amount (called "imputed income") must be added to your W-2 taxable income. Imputed income is reported and taxes are withheld on a biweekly basis according to procedures established by the Internal Revenue Code. Any premiums you pay for life insurance coverage help offset your imputed income amount, thereby reducing the taxes you are required to pay.

Please note that GUL insurance is not subject to the imputed income rules that apply to regular group term life insurance.

Conversion Privilege

Regular Group Term Life Insurance. If your regular group term life insurance coverage ends because your employment ends or you are no longer eligible for coverage, you may convert a portion of your coverage to an individual policy without providing evidence of good health. (You may also be eligible to convert your coverage to a separate policy if the group contract ends. Please contact the Benefits Office for additional information.) Your coverage amount under the new policy must be less than or equal to the amount of regular group term coverage you had under this plan. You may purchase any type of individual policy issued by the insurance company **except** term insurance. The conversion policy will not include disability or other additional coverage features offered under the ***Benefits by Design*** plan.

If you want to convert your coverage to an individual policy, you must apply and pay the first premium within 31 days after your insurance coverage under this plan ends. Your cost for coverage on the converted life insurance amount will be based on the insurance company's current rates for your age and amount of coverage. Coverage under your individual policy will be effective after 31 days from the date your coverage under this plan ends.

If you die during the 31-day time period in which you could have converted your coverage, your beneficiary will receive a benefit equal to the coverage amount you would have had under the individual conversion policy.

Contact the Benefits Office for details about how to convert your group term life insurance coverage.

GUL Insurance. If your face amount of GUL coverage ends due to the termination of all face amounts of insurance under the group contract, you may be able to convert your coverage to an individual life insurance contract without proof of insurability. To be eligible to convert GUL coverage under this provision, you must have been covered (under this GUL coverage and the

predecessor Prudential group term life insurance plan) for at least five years before the date your coverage ends.

If you want to convert your GUL coverage to an individual policy, you must generally apply and pay the first premium by the later of:

(1) The thirty-first day after your Face Amount of GUL insurance ends, or

(2) The fifteenth day after you are given written notice of the conversion privilege.

Please note that in no event may insurance be converted to an individual contract if you do not apply and pay the first premium before the ninety-second day after your Face Amount of GUL insurance ends.

The maximum amount of GUL insurance that may be converted under this provision is generally the lesser of:

The total amount of your insurance under GUL coverage just before the Face Amount of insurance coverage ends, minus

The amount of your fund that is needed to cancel any outstanding loan, minus

The amount of any paid-up insurance that is purchased from your fund just after the Face Amount of insurance coverage ends, ***or***

$10,000.

Your cost of coverage for converted insurance will be based on the insurance company's current rates for your age, coverage level, and class of risk (other than gender). Coverage under your individual policy will be effective after 31 days from the date your Face Amount of insurance coverage under this plan ends.

If you die within 31 days of when the Face Amount of your insurance ends, during a period when you have the right to convert your GUL coverage to an individual contract, your beneficiary will receive a death benefit equal to the coverage amount you would have had under the individual conversion policy (subject to reduction by the amount of any extended death benefit protection which may apply).

Dependent Life Insurance

You may purchase coverage for your spouse only, your children, or for both your spouse and children. You are the beneficiary of any life insurance coverage you have for your dependents.

The annual enrollment period is the only time you may change your choice of dependent life insurance coverage, unless you have a qualified family status change. If you have a qualified change in family status you must notify the Benefits Office in writing within 30 days of the change and complete the necessary change forms, generally within 60 days. The only exception to this rule is for employees who have a new baby while enrolled in dependent insurance coverage for children. Coverage for additional newborn children is automatic under the terms of the plan.

You may not be covered both as an employee and as a dependent spouse. Dependent children cannot be covered by more than one employee. Employees are expected to observe these rules. Duplicate life insurance benefits will not be paid by the insurance company, and premiums for such coverage will be reimbursed only if administratively feasible.

Life Insurance for Dependent Spouse. The options for life insurance on your spouse are 1, 2, or 3 times your annual base salary, (to a maximum of $500,000) subject to the following limitations:

You may not choose more life insurance for your spouse than you choose for yourself.

You may not be covered both as an employee and as a spouse.

If you enroll in dependent spouse life insurance when you are first eligible to participate, you will be able to choose any level of coverage ***except 3 times your salary*** without providing proof of good health. Employees who initially enroll for dependent spouse life insurance coverage equal to 3 times their salary will be required to provide proof of good health. In this situation, coverage will be limited to 2 times salary until the Benefits Office is notified that the proof of good health has been reviewed and approved by the insurance company. Coverage will be increased to 3 times salary effective the first of the month following this notification.

If you enroll in dependent spouse life insurance when you are first eligible to participate, and choose to increase your level of coverage at a later date, you will be required to provide acceptable proof of good health before the higher coverage will be effective. For example, proof of good health will be required if you enroll initially for dependent spouse life insurance coverage equal to 1 times your salary and later wish to increase your coverage to 2 times your salary. In this situation, your dependent spouse life insurance coverage will remain at 1 times your salary until the Benefits Office is notified that the proof of good health has been reviewed and approved by the insurance company. Coverage will be increased to 2 times salary effective the first of the month following this notification.

If you do not enroll in dependent spouse life insurance when you are first eligible to participate, you will be required to provide acceptable proof of good health to enter the plan at a later date (even for the lowest level of coverage). Your coverage will not be

effective until the first of the month following the month in which the Benefits Office receives notification that your proof of good health has been reviewed and approved by the insurance company.

The 1999 cost of life insurance on your spouse is determined using the age-rated premium (for your age) from the table that follows:

Age	Cost/$1,000/Month
<30	$0.048
30 – 34	$0.058
35 –39	$0.084
40 – 44	$0.116
45 – 49	$0.236
50 – 54	$0.400
55 – 59	$0.700
60 – 64	$1.010
65 – 69	$1.764
70 +	$3.152

Your contributions for life insurance on your spouse will increase automatically (the first of the following month) if you have a salary increase that causes the amount of coverage to be higher, or if you have a birthday that causes you to move into a new age band.

Life Insurance for Dependent Children. Life insurance for your dependent children aged 14 days to 21 years is available through ***Benefits by Design*** as follows:

Age	Option 1	Option 2
14 days to 6 months	$2,500	$6,250
6 months to 21 years	$10,000	$25,000

Please note that if both you and your spouse work for the company, only one of you may elect dependent coverage for your children. Also, you may not carry more life insurance on your children than you carry on yourself. As explained earlier in this section, employees are expected to observe these rules. Benefits for duplicate coverage will not be paid, and premiums for such coverage will generally not be refunded.

If you enroll in dependent child(ren) life insurance when you are first eligible to participate, you will be able to choose either level of coverage without providing proof of good health. If you initially enroll in dependent child(ren) life insurance coverage in the amount of $10,000 and choose to increase the level of coverage to $25,000 at a later date, you will be required to provide acceptable proof of good health for each child before the higher coverage will be effective. If you do not enroll in dependent child(ren) life insurance when you are first eligible to participate, you will be required to provide acceptable proof of good health for each child in order to enter

the plan at a later date (even for the lowest level of coverage). Where proof of good health is required, coverage at the requested level will not be effective until the first of the month following the month in which the Benefits Office receives notification that the proof of good health has been reviewed and approved by the insurance company.

Eligible Dependents. Your eligible dependents for life insurance coverage include:

Your lawful spouse

Your unmarried dependent children from 14 days old to 21 years old. Children aged 19 and 20 must be wholly dependent on you for support and enrolled as full-time students in a school.

Your unmarried dependent children ages 21 and older who were covered under the plan on their 21st birthday and also were fully handicapped on their 21st birthday. Your child is fully handicapped if both of the following conditions are satisfied:

- He/she is not able to earn his/her own living because of mental retardation or a physical handicap which started prior to the date he/she reaches age 21.
- He/she depends chiefly on you for support and maintenance.

"Children" include your natural born children, legally adopted children, and stepchildren living in your home and principally dependent on you for support.

Your spouse and/or child(ren) are not eligible for coverage under ***Benefits by Design*** dependent life insurance in any of the following situations:

If they are on active duty in the armed forces of any country.

If they are insured as an employee under the employee group term life insurance contract.

If they are protected under any employee term life coverage of the group contract after their insurance under that coverage ends.

Employees enrolled in dependent insurance for children do not need to report additional children in order to add them to their coverage. Coverage for additional children is automatic under the terms of the plan.

Cost of Dependent Coverage. If you elect dependent life insurance, you pay the entire cost of coverage with after-tax dollars.

When Dependent Coverage Ends. Coverage for your dependents ends the last day of the month in which your coverage ends, you are laid off, your employment terminates for any reason (including Administrative Leave of Absence or disability), or you stop making contributions for dependent coverage. Coverage ends immediately when a dependent is no longer eligible as

defined, the plan ends, or (in the case of a child) neither you nor your spouse are insured under this plan.

Continuation of Dependent Life Insurance During Leave of Absence. You may not continue dependent life insurance coverage if you are laid off or terminated due an Administrative Leave of Absence.

Dependent life insurance coverage may be continued during Family Medical Leave (FML), Inactive Employee Status (IES), and Military Leave for Active Duty (ML), if you pay any required premiums to the Benefits Office in advance of each month's coverage. If premium payments are not received in advance (by the 20th day of the month preceding the month for which they are due), your dependent life insurance coverage will be canceled as of the last day of the month for which your premium has been paid.

If your coverage is canceled during FML, IES, or ML and you later return to active full-time work, you will be required to provide proof of good health for your spouse and/or each covered child. Your dependent life insurance coverage will not be effective until the proof of good health is reviewed and approved by the insurance company.

Taxes on Dependent Life Insurance. The ***Benefits by Design*** dependent life insurance plan will comply with all legal requirements for taxation of the value of dependent life insurance. Please contact the Benefits Office for more information.

Conversion Privilege for Your Dependents. Your dependent may convert this insurance to an individual policy when his/her coverage ends as stated above. Your dependent's coverage under the new policy may be less than or equal to the amount of coverage your dependent had under this plan.

To convert your dependent's coverage, you must apply and pay the first premium within 31 days after the dependent's coverage ends. No proof of good health is required.

Your dependent may elect any type of policy issued by the insurance company except term insurance. The conversion policy will not include disability or other additional coverage features offered under this plan.

If your dependent dies within 31 days after coverage under this plan ends, the insurance company will pay you the full coverage amount in effect for your dependent when coverage ended.

Life Insurance After You Retire

Employee Life Insurance. If you begin drawing your retirement from the INEEL Employee Retirement Plan at the time you terminate from active employment with the company, you may continue a portion of your employee life insurance.

Retirement Prior to January 1, 1998. Employees who retired prior to January 1, 1998 do not participate in GUL insurance. These employees were allowed to continue (as regular group term life insurance) life insurance equal to the lesser of:

$2,000 plus 2 times their annual single life retirement annuity, or

One-half of the amount of life insurance in effect on the last day of their full-time employment

$400,000.

The cost of retiree group term life insurance is subject to change. Premiums are deducted from your monthly retirement benefit payments.

Participants who retired before January 1, 1998 should contact the Benefits Office if they have questions about their life insurance coverage.

Retirement On or After January 1, 1998. Employees who retire on or after January 1, 1998 will have the following options for continuing their life insurance coverage.

Regular group term life insurance may be continued equal to the lesser of the following amounts:

$2,000 plus 2 times their annual single life retirement benefits, ***or***

One-half the amount of regular group term life insurance in effect on the last day of full-time employment.

The cost of retiree group term life insurance is subject to change. Premiums will be deducted from your monthly retirement benefit payments.

GUL insurance may be continued in accordance with the rules described earlier under "Continuing GUL Coverage." Premiums for continued GUL coverage will be payable directly to KVI (before November 1, 1999) or Prudential (on or after November 1, 1999).

Dependents Life Insurance. If you have dependent life insurance under this plan at the time of your retirement under the INEEL Employee Retirement Plan, a portion of the coverage may be continued as follows:

Dependent	Amount of Coverage
Spouse	$5,000
Dependent children ages 14 days to 6 months	$500
Dependent children ages 6 months to 21 years	$2,000

The amount of dependent life insurance for any covered dependent cannot be more than the amount of your own life insurance. Dependent life insurance coverage ends if you die.

If you elect to continue dependent life insurance after you retire, the cost for coverage will be deducted from your monthly retirement benefit payments.

Filing a Claim

If you die, **your beneficiary** should contact the Benefits Office (526-2000) to file a claim for benefits under the plan. If your dependent dies, **you** should contact the Benefits Office (526-2000) to request the necessary forms for filing a claim. Claims for benefits should be completed and filed within 30 days after the loss, or as soon as reasonably possible.

Benefit payments will be made either in a lump sum or in installments.

Retirement Plan

Introduction

An important question for you to consider is the financial security you will have after you retire. The INEEL Employee Retirement Plan is designed to provide you with an income in addition to your Social Security benefits, and to assist you in maintaining financial independence during your retirement years. The plan may also provide you or your family with valuable benefits if you become disabled or die before retirement.

This plan summary describes the INEEL Employee Retirement Plan as in effect on October 1, 1999. Although the Plan Administrator intends to advise you when your benefits may be affected by a plan amendment and/or changes in the law, it is possible that this summary may not at all times reflect all recent changes to the plan or applicable provisions of recently enacted laws. If at any time there is a discrepancy between the terms of the plan document and this summary, the plan will govern. Of course, the plan in operation must always comply with applicable laws.

Highlights of the Plan

Retirement Ages. Normal retirement age is 65. If you retire at age 65, you can receive full benefits from the plan.

Early retirement with **unreduced** benefits may start as early as age 62. Early retirement with **reduced** benefits may start before age 62 if you meet certain requirements.

Late retirement occurs after age 65 if you continue working for the company.

Funding the Plan. The company pays most of the cost of the retirement plan. You will contribute to the plan if your salary is above the Social Security wage base.

Vesting. You become fully vested in your retirement benefit after you complete 5 years of cumulative service or if you are an employee on or after your 65th birthday. You also become fully vested if you end employment due to disability as defined in the plan. When you become fully "vested" in your retirement benefit you "own" all your retirement benefit.

You are always vested in your own contributions (if you make contributions), plus credited interest. This means that if your employment ends before you are fully vested you will be entitled to a benefit based on the value of your contributions.

Retirement Benefits. Benefits are calculated using the plan's formula(s). Benefit amounts are based on your earnings while you are a participant and your years of participation in the plan.

Forms of Benefits. Retirement benefits are payable for your lifetime if you are not married when benefits start. If you are married, you may draw your retirement benefit over your lifetime only, or you may choose to draw a lesser retirement benefit over your lifetime and provide a survivor benefit for your spouse in the event of your death. Under certain circumstances, the present value of all or part of your vested retirement benefit may be paid in a single, lump sum payment. Optional forms of benefit payment are chosen before benefits start.

Pre-Retirement Survivor Benefits. If you are married and die before you begin receiving benefits, your spouse may receive a survivor's benefit based on your vested retirement benefit.

Your survivor will always receive the full value of **your contributions** to the plan, plus interest, if you die before benefits start.

Disability Service Credit. If you become disabled as defined by the terms of the plan, you can continue to earn service credit under the retirement plan provisions in effect at the time the disability is incurred.

Changes to the Plan. Federal legislation often has an effect on the provisions of this plan. The INEEL Retirement and Investment Plans Committee will study all new laws and regulations to determine the best means of complying with new legal requirements. You will be informed of any plan changes. If the plan is amended, the benefits you earned as of the date of the ammendment cannot be reduced. Any ammendment to the retirement plan will be in writing and signed by the Plan Sponsor.

Joining the Plan-Eligibility

Regular Full-Time Employee. If you are a regular, full-time employee, you are eligible to join the retirement plan (1) on the first day of the month following your employment date if you are hired prior to the 20th of the month or; (2) on the first day of the second month following your employment date if you are hired on or after the 20th of the month. Participation in the retirement plan is not automatic; you must make a positive election (on a form available from the Benefits Office) to participate in this plan.

You are a regular, full-time employee under this plan if you are normally scheduled to work full-time, and you are identified as a regular full-time employee on the company's records.

Regular Part-Time or Temporary Employee. If you are a regular part-time or temporary employee, you are eligible to join the retirement plan the first day of the month after you complete a year of eligibility service. You earn a year of eligibility service if you are credited with at least 1,000 hours of service in a 12-month period counted from your date of hire, or in any subsequent plan year.

Definition of a Regular Part-Time or Temporary Employee. You are a regular part-time or temporary employee if you are hired for a specified period of time or on a part-time basis and are identified as a regular part-time or temporary employee on the company's records.

Delayed Enrollment. If you don't join when you are first eligible, you may join the plan the first day of any subsequent month as long as the Benefits Office receives your application by the 20th day of the month before the effective date of your participation.

Important Terms Affecting Your Benefit

Terms used in this handbook section which have special meanings for the plan or are used to determine the amount of your benefit are defined below.

Break in Service occurs if you leave the company and are gone more than one year.

Committee means the INEEL Employee Retirement and Investment Plans Committee, which directs the operations of the plan.

Company means Bechtel BWXT Idaho, LLC (BBWI) and any other DOE-ID contractor which adopts this plan with the approval of the Committee.

Covered Compensation is determined by your year of birth and is calculated in the year you retire or otherwise end employment. It is equal to the average of the maximum Social Security wage base amounts over the 35 years preceding your normal retirement date, and changes each year as the Social Security wage base changes. Sample average covered compensation amounts are available from the Benefits Office.

Credited Service is used in the benefit formula to determine the amount of retirement benefits you will receive under the plan's benefit formula(s).

When you participate in the plan, you earn a year of credited service (or a partial year for a period of less than a full year) based on your elapsed time as a company employee during each plan year (October 1 to September 30). Elapsed time starts with the date you become a participant in the plan, and ends on the earliest of your retirement date, your employment termination date, or the date of your death.

You may also earn credited service during periods of disability when you are eligible to receive benefits from the company's long-term disability (LTD) plan.

Credited service does **not** include:

- Time when you are not an employee of the company, except when you are receiving LTD benefits as described in the Section of this Booklet titled "Benefits If You Become Disabled."
- Time when you are not a participant in the plan.
- Any period of participation for which you elected to receive distribution of only your accumulated contributions plus interest, unless you are rehired within 5 years.

- Any period of participation for which you were required to take a distribution of your vested retirement benefit not over $3,500, unless you are rehired within 5 years.

- Any period of participation for which you elected to receive a lump sum payment of your vested retirement benefit if you were fully vested.

- Any period when you are required to contribute to the plan, but you suspend your contributions.

Cumulative Service is used only to determine your eligibility to participate and when you are fully vested in your retirement benefit. Cumulative Service is generally the same as recognized company service. You earn a year of cumulative service for each full year you are a company employee. In certain cases employees who are transferred to the company from an affiliated company, or who are transferred from the company to an affiliated company, receive cumulative service credit for their employment with the affiliated company. Please note the following special provisions that are used in calculating your cumulative service:

1. For plan years beginning before October 1, 1985, cumulative service does not include service before a break in service that is longer than your cumulative service before the break. This applies only if you were not fully vested at the time of your break in service.

2. For plan years beginning October 1, 1985 and after, in the event you were not fully vested at the time of your break in service, cumulative service does not include service before a break in service that is 5 or more years.

3. Cumulative service will include a period of severance that begins on an approved leave of absence or layoff of 1 year or less.

Earnings, if you are a regular full-time employee, is your regular monthly base pay, not including shift differentials, cost-of-living adjustments, overtime, retroactive pay adjustments, lump-sum payments, bonuses or other types of premium pay, except as provided by a collective bargaining agreement. If you are a regular part-time or temporary employee, earnings means your pay that is subject to federal income tax withholding and reportable to IRS on your W-2 form.

Earnings include money you contribute to the INEEL Employee Investment Plan, Medical Plan, Dental Plan, Vision Plan, Accidental Death and Dismemberment Plan, and Flexible Spending Account(s). Your earnings are computed before any deductions you authorize or which are required by law to be withheld from your pay. Earnings do not include any payments by the company on your behalf under any benefit plan.

The federal government imposes maximum limits on the amount of earnings which can be used to calculate your benefits. You will be notified if you are affected by these limits.

Final Average Monthly Earnings (FAME) means the average of your monthly salary amounts for the 36 consecutive months (out of the last 60 months of your employment) in which your salary is the highest.

LTD Participant is a disabled participant who is receiving benefits under the Company's long-term disability (LTD) plan. A disabled participant who is not covered under the LTD plan will be an LTD participant if it is determined by the Committee that he/she would have qualified for LTD benefits.

Period of Severance means a period of absence from the Company. Employees who do not complete at least 1 hour of service during a consecutive 12-month period, starting on the severance date, will have a 1-year period of severance. Severance does not include paid leaves of absence (such as personal leave, short-term disability bank usage, court leave, death in family leave, and military leave for training), or unpaid leaves of absence which do not involve employment termination (including time off without pay, Family and Medical Leave of Absence, Inactive Employee Status, military leave of absence for active duty or professional leave of absence). Additionally, severance does not include a layoff, Administrative Leave of Absence, or Professional Leave of Absence (involving an employment termination) for 1 year or less.

Your severance date is the earliest of:

The date you end employment with the company (unless you are placed on layoff or an approved leave of absence) or with any of its affiliated companies after a transfer.

The date your employment terminates if you are scheduled to return to work from a leave of absence or layoff of one year or less from the company, but you do not report for work

The date one year after the start of any layoff or approved leave of absence from the company, if you return to work.

Plan means the INEEL Employee Retirement Plan.

Social Security Wage Base is the maximum amount of annual salary on which you and the company must pay Social Security (OASDI) taxes. This base is set each year by the Social Security Administration.

Vested Retirement Benefit is the part of your retirement benefit calculated using the plan's benefit formula that is fully vested and nonforfeitable.

Financing the Plan

Company Contributions. The company contributes an amount to the retirement plan which, when combined with funds contributed by certain participants, will be enough to fund the plan benefits on a sound financial basis.

The company's contributions to the plan are based on calculations prepared by an independent enrolled actuary. The actuary prepares a periodic report that summarizes all plan activity for the previous plan year and recommends how much the company should contribute based on the number and ages of plan participants, the current amount of the plan fund, and the benefits provided by the plan.

Your Contributions. Employees whose calendar year earnings exceed the Social Security Wage Base established for such year are required to contribute 4% of their excess earnings to the Retirement Plan. These contributions begin at such time in the calendar year as the employee's earnings have actually exceeded the Social Security Wage Base, and continue for the remainder of that year. Contributions to the plan, if any, are made by payroll deduction on an after-tax basis.

Contributions and credited interest on your contributions are 100% nonforfeitable. This means that you are guaranteed and are fully vested in (you "own") these amounts at all times.

You earn interest on your contributions at an annual rate that is **at least** the minimum interest rate required under the Employee Retirement Income Security Act (ERISA) of 1974.

You may not withdraw your contributions while you are still employed by the company or an affiliated company. You may elect to suspend your contributions for a minimum period of 12 months. During this period of suspension, you will not receive credited service toward your retirement benefit, but your cumulative service during this time will count toward your eligibility for **vesting** in your retirement benefit.

If you end employment while you are covered by the retirement plan, the balance of your contributions as of the date you end employment will be calculated as the sum of your contributions plus credited interest, and will be payable to you subject to certain conditions. For more information, see the section in the entitled "Optional Separate Lump-Sum Payment of Your Contributions Plus Credited Interest."

If you die before you retire, your survivor will receive a benefit from the plan of **at least** the sum of your contributions plus credited interest. See the section of this book entitled "Payment of Your Contributions if You Die Before Your Retirement Benefits start."

Trust Fund. The contributions made by you and the company are deposited in a trust fund. The money in the fund is used to provide retirement benefits according to the provisions of the plan.

Under the terms of the plan, the money in the Retirement Plan fund must be used to provide benefits for plan participants. The company cannot use any of the money in the fund, except under limited circumstances.

Calculating Your Retirement Benefit

Your monthly retirement benefit is determined by comparing the amounts from two formulas. The higher benefit amount produced from the two formulas will form the basis for your retirement benefit (subject to reduction for the cost of the pre-retirement death benefit), payable for life on your retirement at age 65. Other retirement ages and forms of benefit payment may also be available to you, in which case the monthly benefit amount will be adjusted.

Terms used in the formulas are defined in the previous section. "FAME," as used below, stands for final average monthly earnings.

Formula 1

Monthly Retirement Benefit =

1%	X	FAME **up to** covered compensation	X	Years of credited service
		PLUS (+)		
1.8%	X	FAME **above** covered compensation	X	Years of credited service

Formula 2

Monthly Retirement Benefit =

1.2%	X	FAME	X	Years of credited service

Current employees who were on the payroll on August 31, 1980 and have not had a break in service, will also be eligible for benefits under another formula which was in effect at that time, if the old formula produces a larger benefit. You may contact the Benefits Office for a description of this formula.

Retirement Dates

Normal Retirement. Normal retirement age under the plan is 65.

You will be eligible to receive the full amount of your vested retirement benefit as calculated under the plan's benefit formula (subject to reduction for the cost of the pre-retirement death benefit), starting on your normal retirement date. Your normal retirement date is the first day of the month on or after your 65th birthday.

Early Retirement. The earliest age at which you may retire under the plan is 55.

You may elect early retirement, effective on the first day of any month on or after your 55th birthday, if you have completed 5 years of cumulative service. You do not need to complete 5 years of service if you were 55 years of age or older on October 1, 1990.

Your early retirement benefit will be based on your credited service and final average monthly earnings as of your early retirement date. The benefit amount will be calculated using the plan's benefit formula and normal retirement age (age 65). Adjustments will then be made to this amount for the cost of the pre-retirement death benefit option (if applicable) and the appropriate reduction for early retirement.

You may elect to have your retirement benefit payments start as early as age 62 without any reduction for early retirement.

If you elect to have your benefit payments start between ages 55 and 62, the amount of the payments will be reduced by .25% for each month (3% per year) that payments start before age 62. Your retirement benefits are reduced if you retire early because they will probably be paid for a longer period of time.

Calculating the early retirement reduction in the manner described above provides a substantial subsidy to individuals who continue their employment with the company to age 55 or older and elect to retire between the ages of 55 and 64. Please note that this subsidy is generally available only to those employees who do not terminate their employment prior to being eligible to retire. A comparison of (1) the subsidized early retirement benefits available for employees who work to at least age 55, and (2) the actuarially reduced benefits available for employees who terminate their employment prior to reaching age 55, is included in the table that follows.

Example: The subsidized plan benefit payable at age 55 is 79% of the accrued benefit payable at age 65, compared with 39% on an unsubsidized basis. Therefore, a participant who works to age 55 and then begins drawing his/her retirement benefits receives 103% more than he or she would if the special plan subsidy did not exist.

Percentage of Age-65 Benefit Payable If You Retire Between Ages 55 and 64

Age at Termination	65	64	63	62	61	60	59	58	57	56	55
A. INEEL Plan (work to age 55 or older)	100	100	100	100	97	94	91	88	85	82	79
B. Unsubsidized Benefit-Actuarial Reduction (do not work to age 55 or older)	100	90	81	74	67	61	55	51	46	42	39
C. Percentage Difference	0%	11%	23%	35%	45%	57%	65%	73%	85%	95%	103%

Early Retirement – Firefighters. If you are a firefighter and have completed at least 5 years of cumulative service you may be eligible to start an early retirement benefit before age 55.

If you are a firefighter who became an employee of the company in 1993 and were never covered under a collective bargaining agreement, you may elect early retirement at age 50. If you have completed at least 30 years of cumulative service, your retirement benefits will not be reduced. If you have not completed at least 30 years of cumulative service, benefits will be reduced 3% for each year of cumulative service less than 30, or for each year of attained age less than 62 (but not below age 50), whichever is the smaller reduction.

If you are a firefighter covered under the Paper, Allied-Industrial, Chemical & Energy Workers International Union Local 2-652 (Firefighters) Working Agreement, and have completed at least 30 years of cumulative service, you may elect an unreduced early retirement benefit regardless of your attained age. If you have not completed at least 30 years of cumulative service, you may elect an early retirement benefit starting at age 55, reduced 3% for each year of cumulative service less than 30, or for each year of attained age less than 62 (but not below age 55), whichever is the smaller reduction.

Late Retirement. You may decide to continue working beyond age 65 and retire at a later date. In this case, your retirement date will be the first day of the month after you actually terminate your employment. Your retirement benefit will be calculated under the plan's formula, using your credited service and final average monthly earnings as of your actual retirement date. If you work beyond age 70-1/2, you may elect to start payment of your retirement benefits while you are still working. When your employment ends, your retirement benefits will be increased for any additional benefits that you earned.

When You Are Ready to Retire. With your manager's approval, you should contact the Benefits Office about 4 weeks before your retirement date for an appointment to complete the

necessary forms to retire. Retirement is effective on the first day of the month following your termination date. The regular termination procedure should be followed.

When Payments Begin. Benefit payments will normally begin as of the first day of the month after you retire. If you continue working beyond age 65, you may elect in writing to defer the start of your benefits. Your retirement benefit payments **must begin** by April 1 of the year after you reach age 70½, even if you are still working for the company.

Forms of Benefit Payment

The normal form of payment of your vested retirement benefit is a lifetime income payable monthly beginning at normal retirement (age 65), calculated using the plan's formula(s). Your benefit can be paid in one of the following ways.

Automatic Form for a Single Participant - Single Life Annuity. If you are single when your benefits start, you will receive your vested retirement benefit payments as a single life annuity over the remainder of your lifetime. Under this form of payment, there are no survivor benefits.

Automatic Form for Married Participant—Joint and 50% Survivor Annuity. If you are married when benefits start and do not make any other election, your vested retirement benefit will automatically be paid in the form of a joint and 50% survivor benefit (see below), with one-half of your benefit payable to your surviving spouse (for the remainder of his/her lifetime) after your death.

If you choose to provide a 50% survivor benefit for your spouse, the payments received over your lifetime will normally be 10% to 20% lower than the benefits payable under the normal form (single life annuity). This reduction is made because your spouse continues to receive a benefit after you die, so that usually your retirement benefit is paid over a longer period of time. For example, if your monthly benefit is $100 per month under the single life annuity, you could expect to receive approximately $80 to $90 per month under the joint and 50% survivor form of payment, depending on your spouse's age.

Examples 2 and 4 on the pages that follow show benefit calculations for the automatic form of payment.

Optional Form for Married Participant—Joint and 100% Survivor Annuity. If you are married and do not wish either the automatic joint and 50% survivor annuity or the single life annuity form of payment, you may elect a joint and 100% survivor option with your spouse as beneficiary.

This option provides a reduced benefit for your lifetime. After your death, your spouse will receive 100% of your benefit amount.

An illustration of the benefits under the 100% option is shown in Example 5 on the pages that follow.

Optional Form for Married Participant – Single Life Annuity. You may elect to draw your vested retirement benefit as a single life annuity if you are married and wish to waive (give up) your right to the automatic form of payment (see below). Because the single life annuity form of payment will not provide a survivor benefit to your spouse in the event of your death, your spouse must agree in writing to your election (see Spousal Consent in this section).

Optional Lump-Sum Payment of Vested Retirement Benefit. If the present value of your vested retirement benefit is between $3,500 and $10,500 when payment is to be made, you may waive your right to automatic annuity payments and elect a single, lump sum payment, subject to the spousal consent requirements described under the "Spousal Consent" section. In this case, no further benefits will be payable to any person.

The present value of your vested retirement benefit is determined using a combination of your attained age, the plan's interest rate, and your accrued benefit at normal retirement age. You should discuss eligibility for a lump-sum payment and the effect on your retirement benefits with the Benefits Office.

Optional Separate Payment of Contributions Plus Credited Interest. Under the terms of the plan your contributions plus credited interest are part of your vested retirement benefit and payable in the automatic annuity form. If you choose, you may waive (give up) the automatic annuity form of payment for your contributions plus credited interest and elect a separate single, lump sum payment of that amount, with the consent of your spouse. (See "Spousal consent" section.) In this case, the vested retirement benefit you may be eligible to receive will be reduced for the amount of that payment.

Automatic Lump-Sum Payment. If you leave the company and all affiliated companies when the present value of your vested retirement benefit is $3,500 or less, your benefit will be paid to you (or your survivor) in a single, lump-sum payment. Annuity payments will not be available.

Minimum Payment Amount. Regardless of the form of payment you elect, you and/or your beneficiary are guaranteed to receive a retirement benefit equal to at least the value of the amount you contributed to the plan, plus interest.

Spousal Consent. If you are married and choose to receive a single life annuity instead of the joint and 50% or joint and 100% survivor option with your spouse as beneficiary, your spouse must agree in writing to this form of payment. The agreement must be notarized or witnessed by a plan representative. (Spousal consent forms for this purpose may be obtained from the Benefits Office.) You must return the spousal consent form to the Benefits Office about 4 weeks

before payments are to begin. You cannot begin receiving benefits until a properly completed form is received and approved by the Committee or its representative.

Taxation of Benefit Payment and Rollovers

Generally, you will be subject to ordinary federal income taxes on payments of your retirement benefits except any portion that is attributable to your own contributions, as determined under IRS regulations.

If you choose a single, lump-sum payment of all or a part of your vested retirement benefit, 20% of the taxable part of the payment will be withheld automatically for federal income taxes at the time you receive the money. If you are not at least age 59 1/2, you may also be liable for an additional 10% early payment penalty tax on the taxable part, unless one of the exceptions applies.

You may defer federal income taxes and avoid the mandatory 20% withholding on your lump-sum payment by electing a direct rollover from the retirement plan to your Individual Retirement Account (IRA) or another employer's qualified plan. The minimum direct rollover amount is $500.

Applying for Benefits

To initiate payment of your retirement plan benefits, you should apply in writing to the Benefits Office about 4 weeks before your benefit is to begin. A set of retirement application forms will be prepared for you, and you should then make an appointment with the Benefits Office (526-2000, Option 7) to review and discuss these forms.

Within a reasonable time following the receipt of your completed retirement application, and prior to your retirement date, you will receive an explanation of the forms of benefit payments available to you and the terms and conditions, if any, of each option. This notice will also explain your right to elect or reject certain options and the possible effects of your actions.

If you are married and do not select a payment option, your benefits will be paid as a joint and 50% survivor annuity. If you are not married, your benefits will be paid as a single life annuity.

If You Leave Before You Are Eligible for Early Retirement

If you end employment with the company and/or its affiliated companies before you are eligible for payment of an early retirement benefit, and the present value of your vested retirement benefit is over $3,500, you may be eligible for retirement benefits from the plan as described below.

Refunding of Contributions. You may choose to receive immediate payment of the value of your contributions, including credited interest, or you may defer payment until your retirement benefits start. If you elect payment of the value of your contributions before you are eligible to start retirement benefits, payment is made as described in the Section titled "Optional Separate Payment of Contributions Plus Credited Interest."

Benefits Before You Become Fully Vested. If you end employment for any reason before you have completed at least 5 years of cumulative service or are eligible for early retirement benefits, payment will be based only on the value of your contributions plus credited interest.

Deferred Benefit. If you end employment after you have earned a vested retirement benefit from the plan, but before you are eligible for an early retirement benefit, you will be entitled to a vested deferred retirement benefit. Your vested deferred retirement benefit is payable beginning at your normal retirement date (age 65), or at your election, beginning when you are eligible to start an early retirement benefit. You may make a written election to defer payment to age 70-1/2. If you elect to start payments before age 65, your benefits will be actuarially reduced, as shown in the table included in the section titled "Early Retirement."

If You Are Transferred To An Affiliated Company

If your employment is transferred to an affiliated company, you will not be eligible to elect a distribution of your vested retirement benefit until your employment with the affiliated company ends. If you are not fully vested when you are transferred, you will receive cumulative years of service credit (towards vesting only) for your employment with the affiliated company.

If You Are Rehired

The following provisions will be applied if you terminate your employment and are subsequently rehired:

If you were not vested when you ended employment, your previous cumulative and credited service may be retained if you are rehired as described in the cumulative service and break in service sections. Other rules on retaining past service are described here.

If you are rehired after a break in service, any eligible cumulative and credited service from before the break which must be recredited, will be recredited to you when you are rehired.

If you are rehired within 5 years and you previously received a distribution of your contributions plus credited interest only, the total benefit you had earned based on service before you left the company will be restored to you, less any benefit attributable to your contribution and interest previously refunded. The benefit restored will be added to any new benefit that you earn based on credited service after your date of reemployment.

If you were not vested when you terminated and are gone for 5 or more years, you will earn future benefits based on credited service after your date of reemployment only. You will lose your prior cumulative service and credited service.

If you were fully vested at the time your employment ended and you incur a period of severance after July 1, 1976, your cumulative service will include service before your termination when you are later rehired. You earn additional benefits based only on your credited service and earnings after reemployment.

If you are receiving a retirement benefit from the plan and you return to company employment, special rules apply as to how much of your benefit payments will be continued. Please contact the Benefits Office before you resume employment, and they will provide information to you on these issues. When you retire again, your prior benefit payments may be recalculated, taking into account any age differential. You earn additional benefits based only on your credited service and earnings after reemployment.

Leave of Absence or Layoff

Leave of Absence. The impact of a leave of absence on your retirement benefits depends upon the type of leave, as follows:

Paid Leaves of Absence—You continue to earn years of cumulative (vesting) and credited (benefit) service during paid leaves of absence such as personal leave, short-term disability bank usage, holidays, court leave, death in family leave, and military leave for training.

Unpaid Leaves of Absence Where Employment ***DOES NOT*** Terminate – You continue to earn years of cumulative (vesting) service during unpaid leaves of absence in which your employment is not terminated. You may also earn years of credited (benefit) service provided you continue to make any required employee contributions during the leave period. Leaves that are included under this section are time off without pay, Family and Medical Leave of Absence, Inactive Employee Status, Military Leave for Active Duty (not involving an employment termination) and Professional Leave of Absence (not involving an employment termination).

Unpaid Leaves of Absence Where Employment ***DOES*** Terminate – You may earn up to one year of cumulative (vesting) service during an unpaid leave of absence in which your employment terminates, provided you return to active employment with BBWI before the expiration date of the leave including extensions. Leaves included under this section are Administrative Leave of Absence, Military Leave for Active Duty (where employment terminates) and Professional Leave of Absence (where employment terminates).

Except in the case of Military Leave for Active Duty, you will not earn credited (benefit) service during these leaves. Military Leave participants will receive credited (benefit) service based on veterans' reemployment rights as established by federal law.

Layoff. You may earn up to one year of cumulative (vesting) service during a layoff which results in your employment termination. If you become age 55 (and are/become fully vested) during this one year period, you may start to draw a subsidized early retirement benefit (see section on Early Retirement) even though you did not actually retire when your employment terminated with the Company. You will not earn credited (benefit) service during a layoff.

Survivor Benefits—Single Employees

If you are single and die before your retirement benefit payments begin, no retirement benefits are payable from the plan. However, your designated beneficiary would receive a single lump sum payment of your contributions plus credited interest remaining in the plan.

The Company is required to follow your beneficiary designation, so it is important to keep your designation current. However, if you are married on the date of your death before benefits start, your designation of a beneficiary when you were single will be invalid. Your spouse is automatically your beneficiary except under certain circumstances, as explained below.

Survivor Benefits—Married Employees

Spouse's Benefit Before You Retire. If you are vested and you die before benefit payments begin, a benefit will be paid to your surviving spouse (unless you waive this coverage after reaching age 50 by following the procedures outlined below). This benefit is called a "Qualified Preretirement Spouse's Annuity." The benefit is a monthly income payable to your spouse for his/her life.

The amount of benefit is the survivor portion of the joint and 50% survivor option. It is based on your vested retirement benefit, the age you would have been had you survived to the date benefits are to begin, and the age of your spouse when benefits begin.

If the present value of the Qualified Preretirement Spouse's Annuity is not over $3,500 at the date of your death, that present value will be paid to your surviving spouse only in a lump sum. If the present value is over $3,500 but not over $10,500 when payment is to be made, your spouse may waive the annuity benefit and elect a single lump sum payment. In this case, no further benefits will be payable to any person.

Even if the value of the benefit is over $10,500, your spouse may elect a separate single lump-sum payment of the value of your contributions plus credited interest before benefits start, in which case, monthly benefit payments will be reduced.

Payment will begin at your spouse's election, but not earlier than the date you would have been eligible to start early retirement benefits. Benefit payments cannot begin later than April 1 of the year after the later of (1) the year you would have been age 70½ or (2) the year of your death.

Waiving the Qualified Preretirement Spouse's Annuity. You will automatically be covered at no charge under the Qualified Preretirement Spouse's Annuity option before you reach age 50. Your coverage will continue after you reach age 50 and there will be a charge for the coverage (see below), unless you and your spouse choose to waive (give up) this protection. Shortly before you become age 50, the Benefits Office will notify you about the cost of the Qualified Preretirement Spouse's Annuity and the procedure to follow to waive this coverage.

If you wish to waive the Qualified Preretirement Spouse's Annuity option after age 50, you must obtain your spouse's written consent. Both you and your spouse must sign a waiver form available from the Benefits Office. You may rescind a waiver at any time after receipt of the form and up to the earlier of (a) your date of death or (b) the start of benefit payments. The consent of your spouse is not required for your election to rescind your waiver.

If you waive the Qualified Preretirement Spouse's Annuity and die before you retire and retirement benefit payments begin, your survivor will receive only a lump-sum payment of your contributions plus interest. No further benefits will be payable from the plan.

The consent of your spouse to waive the Qualified Preretirement Spouse's Annuity option is only valid for that spouse. If your marital status changes, you may need a new waiver and/or beneficiary designation. It is your responsibility to keep your waiver and/or beneficiary designation current.

Cost of Qualified Preretirement Spouse's Option Coverage After Age 50. If you do not waive the Qualified Preretirement Spouse's Annuity option, the retirement benefits otherwise payable to you will be reduced to reflect the value of this protection from age 50 to your age at retirement. The amount of this reduction is 3/10 of 1% for each year the coverage is in effect between ages 50 and 55 (prorated by month), and 6/10 of 1% between ages 55 and 65.

Payment of Your Contributions If You Die Before Your Retirement Benefits Start. If you are married and die before age 50, the value of your contributions plus credited interest is part of your vested retirement benefit and payable only to your surviving spouse as a Qualified Preretirement Spouse's Annuity or in a lump sum, as explained above. You may not name any other person as your beneficiary.

However, if you waive the Qualified Preretirement Spouse's Annuity (with your spouse's consent) after you reach age 50, you may designate a beneficiary other than your spouse to receive payment of your contributions plus credited interest should you die before retirement benefit payments begin. Your spouse must give written consent to your beneficiary designation.

Minimum Survivor's Benefit. If you die before retiring, your surviving spouse or beneficiary will always receive at least the amount you had contributed plus any credited interest. If you are married, this is true regardless of whether you waive the Qualified Preretirement Spouse's Annuity option.

Survivor Benefits After Your Retirement Payments Begin. If you die after your retirement benefit payments begin, benefit payments will continue to be made to your surviving spouse only if the form of payment you elected provides for survivor benefits (i.e., if you elected the joint and 50% or joint and 100% survivor option).

The only other situations in which survivor benefits would be payable are:

If you die with a single life annuity form of payment, and the total payments at the time of your death are less than the value of your contributions plus credited interest

If you and your beneficiary both die before the total amount of payments equals the value of contributions plus credited interest.

In either of these cases a lump-sum payment of the remainder of the value of your contributions plus interest, minus the amount of total payments, would be made to your (or your spouse's) beneficiary or estate.

Benefits If You Become Disabled

If you become totally disabled and are receiving benefits from the company's long-term disability (LTD) plan, you can continue to earn benefits under the retirement plan as an LTD participant.

If you become totally disabled and are not covered under the company's LTD plan, but would have qualified for LTD benefits if you had been covered, you can also continue to earn benefits as an LTD participant. You must submit a written request to the Benefits Office for a determination that you can continue to earn benefits as an LTD participant because you would have qualified for LTD benefits. The Benefits Office may require you to furnish such documentation as it deems to be necessary or appropriate to make such a determination.

If you reach age 55 and are vested while drawing LTD benefits, you may elect to begin receiving subsidized benefits (see section on "Early Retirement") from the retirement plan even though you did not actually retire from the company at the time your employment terminated. When benefits from the retirement plan begin, any LTD benefits you are receiving will stop.

Your eligibility for continued participation in the retirement plan as an LTD participant will stop when one of the following events occurs:

You can return to work as determined under the LTD plan and you do not rejoin the company

You exhaust your LTD benefits

You retire

You die.

Non-Alienation of Benefits and Qualified Domestic Relations Orders

The retirement plan specifically prohibits alienation or assignment, pledging or other similar use of any benefits, except that the retirement plan must obey Qualified Domestic Relations Orders (QDROs) issued by a court requiring benefit payments to a spouse, former spouse, child or other dependents. These court orders must comply with the requirements of the Internal Revenue Code and be approved by the Plan Administrator before any payments are made.

Plan Benefit Examples

The following examples illustrate plan benefits for a hypothetical employee, Employee A, under various circumstances.

Examples 1 and 2	Normal retirement (age 65)
Examples 3 and 4	Early retirement (age 60)
Example 5	Joint and survivor option (age 65)
Example 6	Benefit on death before retirement (age 60)

Assume the following information for Employee A:

Date of birth	August 31, 1940
Date of participation	September 1, 1980
Normal retirement date	September 1, 2005
Assumed highest average (3-year of last 5 years) earnings	$4,000 per month
Average covered compensation	$3,704 per month
Primary Social Security	$1,020 per month

Assumes no election of cash-out of employee contributions plus credited interest.

It should be noted that in examples 1, 2, and 5, Employee A would be eligible to receive additional monthly income from Social Security.

EXAMPLE 1

NORMAL RETIREMENT
On September 1, 2005 (age 65), 25 years of credited service from September 1, 1980, through September 1, 2005

(Single Life Annuity)

Employee A's monthly retirement benefit is calculated using Methods 1 and 2 below to determine which produces the higher benefit.

Method 1

(a) Highest average earnings 9/1/2005	$4,000.00
(b) Covered compensation	3,704.00
(c) 1% H $3,704	37.04
(d) 1.8% H ($4,000 - $3,704)	5.33
(e) Total credited service on 9/1/2005	25 years
(f) Monthly benefit = [(c) + (d)] H (e)	$1,059.25

Method 2

(a) Highest average earnings 9/1/2005	$4,000.00
(b) 1.2% H $4,000	48.00
(c) Total credited service on 9/1/2005	25 years
(d) Monthly benefit (b) H (c)	$1,200.00

Employee A's monthly retirement benefit at age 65 will be $1,200.00, the higher of 1(f) $1,059.25 and 2(d) $1,200.00.

EXAMPLE 2

AUTOMATIC FORM OF RETIREMENT – MARRIED EMPLOYEES

Payment at Normal Retirement Date
(Joint and 50% Survivor Annuity)

Suppose that Employee A retires at age 65 as in Example 1, and the employee's spouse is age 60 when Employee A retires. The monthly income from the plan, as determined under the normal form (Example 1), of $1,200.00 would be reduced by applying the factor 83.66%, as follows:

Monthly Benefit = .8366 H $1,200.00 = $1,003.92.

The amount of monthly income payable to Employee A under the automatic form of payment is $1,003.92, beginning at age 65. This amount will be payable to Employee A for life.

After Employee A's death, if the spouse survives, the spouse's benefit will be 50% of the $1,003.92, or $501.96 monthly for life.

EXAMPLE 3

EARLY RETIREMENT

On September 1, 2000 (age 60), 20 Years of Credited Service from
September 1, 1980 to September 1, 2000
(Single Life Annuity)

Assume the date of Employee A's retirement is September 1, 2000, rather than the normal retirement date of September 1, 2005.

Method 1

(a) Highest average earnings 9/1/2000	$4,000.00
(b) Covered compensation	3,704.00
(c) 1% H $3,704	37.04
(d) 1.8% H ($4,000 - $3,704)	5.33
(e) Total credited service on 9/1/2000	20 years
(f) Monthly benefit = 1(c) + Id)] H (e)	$ 847.40

Method 2

(a) Highest average earnings 9/1/2000	$4,000.00
(b) 1.2% H $4,000	48.00
(c) Total credited service 9/1/2000	20 years
(d) Monthly benefit = (b) H (c)	$ 960.00

Method 2 ($960.00) would be applicable, because it is higher than 1(f): $847.40.

NOTE: The above benefit is calculated according to the normal form of payment, which is a single life annuity, payable at age 65.

If Employee A wishes to have the benefit payments begin at age 60, the retirement benefit would be calculated by applying the factor 94.0% (shown in the table in the section on "Early Retirement") for age 60:

Monthly Benefit
At Age 60 = .94 H $960.00 = $902.40.

The monthly retirement benefit provided by the plan, beginning at age 60 (September 1, 2000), will therefore be reduced to $902.40.

EXAMPLE 4

AUTOMATIC FORM OF RETIREMENT – MARRIED EMPLOYEES

Payment at Early Retirement
(Joint and 50% Survivor Annuity)

Suppose Employee A is married, as in Example 2, and that retirement occurs at age 60, as in Example 3. The monthly life income from the plan (normal form) of $902.40 payable at age 60, would be further reduced by applying the factor 86.59% to reflect the 50% continuation to the spouse after death, as follows:

Monthly Benefit
At Age 60 = .8659 H $902.40 = $781.39.

Employee A's monthly pension payable at age 60 and thereafter for life is $781.39. After Employee A's death, if the spouse survives, the spouse's benefit will be 50% of the $781.39, or $390.70 monthly for life.

EXAMPLE 5

JOINT ANNUITANT OPTION – MARRIED EMPLOYEES

At Normal Retirement
(Joint and 100% Survivor Annuity)

Suppose that Employee A retires at age 65, as in Example 1, and that the joint annuitant option is elected with 100% of Employee A's income to continue to the spouse who is five years younger (age 60).

The accrued monthly income from the plan of $1,200.00 would be reduced by applying the factor 71.91%, as follows:

Monthly Benefit = .7191 H $1,200.00 = $862.92.

The amount of monthly income payable to Employee A under the plan will therefore be reduced to $862.92, beginning at age 65. This amount will be payable thereafter to Employee A for life.

After Employee A's death, if the spouse survives, the monthly benefit of $862.92 for the spouse will continue for life.

EXAMPLE 6

BENEFIT ON DEATH BEFORE RETIREMENT

Assume that Employee A, while actively employed, dies at exactly age 60, and the spouse is five years younger. Also assume that Employee A had not waived the spouse's benefit option, and that it became effective on the employee's 50th birthday.

The monthly spouse's benefit payable for life is computed as though Employee A had retired with the joint and 50% survivor option in effect and died one day after retirement. This benefit would be reduced by 0.3% × 5, or 1.5% (the cost of the preretirement death benefit option between ages 50 and 55), and 0.6% × 5, or 3% (the cost of the preretirement death benefit option between ages 55 and 65), for a total of 4.5%, to reflect the cost of the spouse's benefit option.

The spouse would be entitled to a monthly life income from the plan of 50% of 95.5% (100% - 4.5%) of $781.39 (Employee A's reduced accrued benefit computed in Example 4), or $373.11.

Investment Plan

Introduction

The Idaho National Engineering and Environmental Laboratory Employee Investment Plan (the "Plan") provides you with an opportunity to enhance your personal financial security. The primary purpose of the Plan is to assist you in accumulating funds that you can apply toward reaching your long-range financial goals, including supplementing your pension with additional income at retirement.

The Company will match a portion of your contributions to the Plan. The portion of your account allocable to your before-tax contributions, Company match contributions, and investment earnings (on all funds) accumulates on a tax-sheltered basis. Assets of the Plan are held in a Trust.

Your funds will continue to accumulate and, at retirement, can provide you with additional financial security. If you should be faced with an earlier financial need, a portion of the funds that you have accumulated in the Plan can be made available to you to meet this need.

The term "Company" as used in this Summary refers to Bechtel BWXT Idaho, LLC.

The term ''Committee'' used throughout this Summary refers to the INEEL Employee Retirement and Investment Plans Committee.

This Summary describes the terms of the Plan as of October l, 1999. Although the Plan Administrator intends to advise you when your benefits may be affected by a Plan amendment and/or changes in the law, it is possible that this Summary may not at all times reflect all recent changes to the Plan or applicable provisions of recently enacted laws. If at any time there is a discrepancy between the terms of the Plan document and this Summary, the Plan document will govern. Of course, the Plan must always comply with applicable laws.

Highlights of the Plan

Recordkeeping and Administration. The record keeping and administration services for the INEEL Employee Investment Plan are provided by The Vanguard Group.

Joining the Plan. Participation in the Plan is entirely voluntary. Regular full-time employees are eligible to participate on the first of the month following their date of hire. Part-time and temporary employees are eligible after completing 1,000 hours of service within an eligibility year. Eligible employees may enroll in the Investment Plan by calling Vanguard at 1-800-523-1188.

Employee and Company Contributions. You may contribute from 1% to 15% of your earnings (as defined in the Plan document and summarized below in *Employee Contributions:*

Definition of Earnings) through payroll deductions. Your contributions may be made all on a before-tax basis or all on an after-tax basis, or you may designate part of your contributions as before-tax and part as after-tax. The amount you contribute may not exceed the annual maximum dollar limit established and adjusted annually by the Internal Revenue Service (IRS).

After you have completed one year of service, your subsequent contributions up to 8% of your earnings will be matched in cash by the Company at the rate of 60%. Additional amounts that you contribute up to 7% of your earnings (for a maximum total contribution of 15%), will not be matched by the Company. Some highly paid employees may not be allowed to contribute the maximum 15% at all times during a Plan year due to limitations under federal tax law.

You may roll over into the Plan all or part of an eligible distribution from another employer's tax-qualified plan. A rollover contribution will not be matched by the Company.

Vesting in Company Contributions. Your right to Company contributions is based on your years of service with the Company. The table below indicates when you will become vested in (or entitled to receive) your Company match money:

Completed Cumulative Years of Service	Percentage of Company Match to Which You are Entitled
Less than 2	0%
2 but less than 3	25%
3 but less than 4	50%
4 but less than 5	75%
5 or more	100%

In addition, you will automatically become 100% vested in the Company match (regardless of your years of service) if:

You are a Company employee on or after your 65th birthday, You die or become permanently disabled while a Company employee,

You retire under the terms of the current INEEL Employee Retirement Plan, or

You are laid off for at least four consecutive weeks as the result of a Company-initiated reduction in force that is designated in writing as a reduction in force that will result in such vesting.

Plan Investments. Your contributions and the Company's matching contributions are invested as you specify. Investment options include the following funds:

Vanguard Prime Money Market Fund*

INEEL Stable Value Fund

Vanguard Total Bond Market Index Fund

Vanguard 500 Index Fund**

Vanguard Windsor II Fund

Vanguard Morgan Growth Fund

Vanguard PRIMECAP Fund

Vanguard International Growth Fund

Lockheed Martin Stock Fund***

* Please note that an investment in a money market fund is neither insured nor guaranteed by the U.S. government, and there is no assurance that the fund will be able to maintain a stable net asset value of $1 per share

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*** The Lockheed Martin Stock Fund is closed to new contributions.

Plan Loans and Withdrawals. Subject to certain limitations described in the Plan, you may borrow a portion of your vested account balance in the Plan. In addition, you may make withdrawals from your vested account balance under certain circumstances while you are a Company employee.

Benefit Distributions. When you separate from the service of the Company for any reason, you normally will be entitled to receive a distribution of your vested interest in your account under the Plan. Withdrawal forms to request Investment Plan distributions may be obtained from Vanguard by calling 1-800-523-1188.

Tax Advantages. The Plan offers special tax advantages for Company contributions, your before-tax contributions, and the investment earnings credited to your account. In sections of this Handbook there are discussions of the taxability of the payment of your interest in the Plan under federal tax rules. These discussions are for informational purposes only and are not intended to constitute tax advice. Also, state income tax laws may differ from federal laws. You should always consult your own tax professional for advice on the taxability of any distribution to you from the Plan.

Plan Benefits at a Glance. The table below provides a summary of key Plan provisions.

What	**When**	**How**
Joining the Plan	Regular full-time employees – The first day of the month following hire date. Part-time and temporary employees – The first day of the month following an eligibility year in which you complete one year of service.	By calling Vanguard at 1-800-523-1188. If your enrollment is made on or before the 15th day of the month, your participation in the Plan will become effective with the first paycheck of the following month. Otherwise, your participation will be delayed until the second paycheck of the following month.
Making a rollover contribution	When you are eligible to participate and have enrolled in the plan.	By making application on a form obtained from Vanguard.
Changing how much you contribute	As frequently as every two weeks. All or a portion of your contributions can be made on a before-tax-basis, subject to the annual dollar limit. Certain highly paid employees may be limited by federal law at some time during the Plan year to less than 15% in contributions.	By calling Vanguard at 1-800-523-1188. Changes requested on or before the fifteenth of the month will become effective the first paycheck of the following month. Changes requested after the fifteenth of the month will be effective the second paycheck of the following month.
Suspending your contributions	As frequently as you wish for a minimum period of 1 pay period.	By calling Vanguard at 1-800-523-1188. Suspension transactions requested on or before the fifteenth of the month will become effective the first paycheck of the following month. Changes requested after the fifteenth of the month will be effective the second paycheck of the following month.
Terminating your suspension	Any time after your suspension has been in effect for at least 1 pay period.	By calling Vanguard at 1-800-523-1188. Suspension transactions requested on or before the fifteenth of the month will become effective the first paycheck of the following month. Changes requested after the fifteenth of the month will be effective the second paycheck of the following month. Changing your contribution amount or investment fund choices does not reinstate contributions after a suspension.
Changing your investment fund choices	As frequently as every two weeks	By calling Vanguard at 1-800-523-1188. Changes requested by 2:00 p.m. (Idaho time) the Thursday before a payday will be effective with that payday.

What	**When**	**How**
Exchanging balances between funds	Daily.	By calling Vanguard at 1-800-523-1188. Exchanges requested by 2:00 p.m. (Idaho time) will be processed effective the end of the day requested. Exchanges requested after 2:00 p.m. (Idaho time) will be processed effective the end of the following day.
Withdrawing your rollover contributions, after-tax contributions, vested Company contributions and related earnings	Twice in a Plan Year.	By calling Vanguard at 1-800-523-1188. Vanguard will send the appropriate paperwork to complete the withdrawal process.
Withdrawing your before-tax contributions	Twice in a Plan Year, if you have a qualified financial hardship after withdrawing all other funds under the Plan and exhausting all other "ready" cash reserves (including taking a loan from the Plan).	By calling Vanguard at 1-800-523-1188. Vanguard will send the appropriate paperwork to complete the withdrawal process.
Taking a loan from your account	As needed for personal reasons or to purchase a primary residence, except that only one loan may be outstanding at a time.	By calling Vanguard at 1-800-523-1188.
Receiving your vested account balance at retirement, disability, or termination	In a lump-sum when you retire, become disabled, or terminate for any reason. You may elect immediate payment or you may elect to defer payment, but not beyond December 31 of the year in which you become age 70 1/2. Upon retirement on or after age 55, you may elect to receive your vested account balance in installment payments instead of a lump-sum.	By Calling Vanguard at 1-800-523-1188. Vanguard will send the appropriate paperwork to complete the withdrawal process.
Plan Year	October 1 to September 30	

Joining the Plan

Eligibility. If you are a regular full-time employee, you will be eligible to join the Plan generally on the first of the month following your date of hire.

If you are a regular part-time or temporary employee, you may join the Plan after one year of service provided that you worked at least 1,000 hours during the year. If you do not work at least 1,000 hours in your first year of employment, but work at least 1,000 hours by the end of any subsequent Plan year, you will earn your year of service for eligibility and may elect to join the Plan at the end of that subsequent year.

In certain cases if you have directly transferred to BBWI from an affiliated company, you will receive years of service credit for your prior employment with the affiliated company. This service will count towards the one year waiting period for Company matching contributions, and also towards your vesting in the Plan.

Once you are eligible to join the Plan, you may do so by calling Vanguard at 1-800-523-1188 and submitting to Vanguard any required paperwork. If your application is received on or before the 15th day of the month, your participation in the Plan will become effective with the first paycheck of the following month. Otherwise, your participation will not become effective until the second paycheck of the following month.

Naming a Beneficiary. When you enroll in the Plan, you will be asked to select a beneficiary–the person who will receive the value of your vested interest in your account in the event of your death. The beneficiary designation form is available from the Benefits Office.

If you are married, your spouse will automatically be your primary beneficiary. If you are married and wish to designate someone other than your spouse as your beneficiary, your spouse must agree in writing by signing the waiver on the beneficiary designation form. Your spouse's signature must be notarized or witnessed by a Plan representative. It is your responsibility to keep your beneficiary information up to date. If you intend to name a beneficiary other than your spouse, it is your responsibility to submit a valid spousal waiver to the Benefits Office.

If you die before your entire vested interest in your account is paid from the Plan and have not designated a beneficiary who survives you, your vested account balance will automatically be paid as provided in the Plan. The Plan currently provides for payment in the following order of priority: (1) to your surviving spouse, (2) to your surviving children, (3) to your surviving parents, (4) to your estate or heirs at law.

Even if you have named a beneficiary to receive benefits under other Company plans, you must still complete a beneficiary designation form for the Plan.

The Company is generally required to follow your properly completed beneficiary designation, so it is important to keep the information current. (Please note, however, that benefits under the Plan must be paid to your surviving spouse if you are married and your spouse has not agreed to an alternate beneficiary designation.) You may need to change your beneficiary designation as your circumstances change (for example, if you get married or divorced, if you have children, or if your beneficiary dies). Once you complete the beneficiary designation form, return it to the Benefits Office. It is your responsibility to have a current beneficiary designation on file.

Definition of Regular Full-Time Employee. A regular full-time employee under the Plan is one who is scheduled to work full-time and is so identified on the Company's records.

Employee Contributions

You may elect to contribute 1% to 15% of your earnings (as defined below). You may change the percentage of earnings you contribute as frequently as every two weeks, by calling Vanguard at 1-800-523-1188.

You must allocate your contribution percentage between before-tax contributions and after-tax contributions (as defined below). The maximum amount that you can designate as before-tax contributions and after-tax contributions combined is 15% of your earnings. For example, if you elect to contribute 15% of your earnings to the Plan, 8% could be before-tax and 7% after-tax. Alternatively, you could designate the whole 15% as either before-tax or after-tax contributions.

Some highly paid employees may be limited by federal regulations to less than 15% in before-tax and/or after-tax contributions at any time during the Plan year.

Definition of Earnings. For regular full-time employee, "earnings" means regular base monthly pay and does not include any pay you might receive for severance or termination pay, lump-sum amounts, retroactive pay adjustments, personal leave cash-outs, shift differentials, cost-of-living adjustments, bonuses, other types of premium pay, or any overtime, except as provided by collective bargaining agreements.

For part-time or temporary employees, "earnings" means all of your pay that is subject to income tax withholding, as reported on your W-2 form, other than severance pay, termination pay, or lump-sum payments.

"Earnings" is not reduced for your before-tax contributions for (a) the Investment Plan, (b) your medical, dental, vision, and accidental death and dismemberment coverage, and (c) your flexible spending account(s). Earnings are computed before any deductions you authorize or that are required by law to be withheld. Earnings do not include any payments by the Company on your behalf under any benefit plan.

Monthly Payroll Deductions. Your contributions to the Plan will be made through payroll deductions. The actual deduction amount you will see on your pay stub will reflect the exact percentage of your earnings that you elected to contribute. You may change the amount of your contribution to the Plan as frequently as every two weeks, by calling Vanguard at 1-800-523-1188.

The Company will send your contributions directly to the Plan Trustee for investment each month.

Federal Tax Law Limitations on Contributions

Annual Dollar Limit on Before-Tax Contributions. In addition to the Plan's 15% employee contribution limitation, federal law limits the amount you may contribute on a before-tax basis to the Plan and all other before-tax savings plans in any calendar year. In 2000 for instance, the before-tax limit is $10,500. This limit is adjusted each year.

You will be notified if this annual dollar limit affects you. If your contributions exceed this limit, further contributions for the rest of the calendar year will be considered after-tax contributions. Any excess before-tax contributions and earnings (losses) for the previous calendar year must be returned to you by April 15.

Special Limitations for Highly Compensated Employees. The Internal Revenue Code (the "IRC") requires that the tax advantages of before-tax contributions and Company contributions be available to employees at all pay levels. To meet this legal requirement, the Committee may limit the contributions of some highly compensated employees to less than 15% of eligible earnings. "Highly compensated employees" are, in general, employees who earn over a certain amount each year. The amount is set by the IRS and for 2000 is $85,000.

Any before-tax contributions by, or matching contributions for, a highly compensated employee for any Plan year over the above federal tax law limitations, and any earnings on those contributions, will be distributed to the employee as soon as administratively practicable after the close of a Plan year. However, any matching contributions and earnings that are not vested or are based on excess before-tax contributions that must be distributed to the highly compensated employee will be deducted from the employee's account and applied to reduce current Company contributions.

Limitations on Annual Additions. Under the IRC, the annual additions (described below) to an employee's account during any Plan year cannot exceed the lesser of $30,000 (adjusted annually) or 25% of the employee's annual compensation. "Annual additions" include the employee's before-tax, after-tax, and matching contributions, but do not include direct rollover contributions.

Any before-tax and after-tax contributions that exceed this limitation, and any earnings on those contributions, will be distributed to the employee as soon as administratively practicable after the close of that Plan year. However, any matching contributions and earnings that were based on excess before-tax contributions will be deducted from the employee's account and applied to reduce current Company contributions.

Before-Tax Contributions vs. After-Tax Contributions. "Before-tax contributions" are contributions that are made to the Plan before income taxes are withheld from your pay. These contributions reduce the amount of income that will be used to calculate your taxes, so that you will pay lower current federal and state income taxes. Please note, however, that federal regulations impose certain penalties and reductions for these funds, which are explained elsewhere in this Handbook.

"After-tax contributions" are contributions that are made to the Plan after income taxes have been calculated and withheld from your pay. These contributions have no effect on the current amount of your federal or state income tax.

Because the Plan meets certain requirements imposed by the IRS, you will not pay current income taxes on Company contributions and fund earnings when they are added to your account(s). Instead, you will be allowed to defer taxes on these amounts until you actually receive a payout from your account(s). Thus, money you would otherwise pay in taxes will stay in the Plan to earn more money for you. You should consult your own tax advisor for further guidance regarding taxes.

Rollover Contributions. If you participated in a savings or other tax-favored retirement plan with a previous employer, you may be entitled to roll over the otherwise taxable portion of your account balance in the prior plan into the Investment Plan. This will allow you to avoid paying income taxes on the money at the time it is distributed from your former plan.

While the Company will not match your rollover contributions, these contributions will continue to grow on a tax-deferred basis through your investments in the Plan. You can decide how you want the funds invested when you transfer the money into the Plan.

Since January 1, 1993, employers have been required to follow strict rules regarding the withholding of taxes from eligible rollover distributions and withdrawals paid to employees. To avoid having these taxes withheld, you can ask your former employer or the financial institution now holding your plan funds to roll over the money directly into the Plan. The Plan Administrator has the right to approve any rollovers into the Plan.

There are a few exceptions to the withholding requirements. For more details, see *Withholding of Withdrawals and Distributions*. Be sure to contact Vanguard (1-800-523-1188) to get the proper forms and instructions before attempting to roll over funds from another plan.

Company Contributions

After you have one year of service, the company will match a portion of your contributions to the Investment Plan. For each $1.00 you contribute to the Plan, up to 8% of your earnings (as defined above in *Employee Contributions: Definition of Earnings*), the Company will contribute $0.60.

Company contributions are paid to the Plan in cash and are deposited in the Plan funds in the same manner and at the same time as your contributions (as described below in *Plan Investments*).

Plan Investments

Investment Funds. The Committee is authorized to establish investment funds to provide alternative investment opportunities for the investment of Plan accounts. At present, ten

investment funds have been established for investing Plan assets (i.e., your contributions, the Company matching contributions, and the earnings on both). Nine of these funds are available to all BBWI employees:

Vanguard Prime Money Market Fund*

INEEL Stable Value Fund

Vanguard Total Bond Market Index Fund

Vanguard Asset Allocation Fund

Vanguard 500 Index Fund**

Vanguard Windsor II Fund

Vanguard Morgan Growth Fund

Vanguard PRIMECAP Fund

Vanguard International Growth Fund.

* Please note that an investment in a money market fund is neither insured nor guaranteed by the U.S. government, and there is no assurance that the fund will be able to maintain a stable net asset value of $1 per share.

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The tenth fund option (the Lockheed Martin Stock Fund) is available only to those BBWI employees who had a balance in the fund on October 1, 1999. (Please note that even for these employees the Lockheed Martin Stock Fund is closed to new contributions.)

Money contributed to your Investment Plan account may be invested in a short-term reserve account for short periods, pending investment in the funds you select.

A brief description of the ten Investment Plan accounts is included below. Additional information on the management, performance or other attributes of the investment funds is available from Vanguard.

Vanguard Money Market Reserves. Vanguard Money Market Reserves—Prime Portfolio seeks the highest level of income consistent with maintaining a stable share price of $1.

The fund invests in short-term, high-quality money market instruments issued by financial institutions, nonfinancial corporations, the U.S. government, and federal agencies. Its holdings may include certificates of deposit, bank-guaranteed securities, corporate IOUs, and other money market instruments, as well as U.S. Treasury and government agency securities and repurchase agreements on such securities. The average maturity of the fund's holdings will be 90 days or less.

INEEL Stable Value Fund. The INEEL Stable Value Fund seeks to provide relatively stable returns, current income, and preservation of principal. The fund is designed to maintain a stable share value of $1.

The fund invests in investment contracts issued and backed by financial institutions. It also invests in "alternative" investment contracts backed by high-quality bonds and bond mutual funds owned by the fund. This diversification helps to protect the fund against losses that might be caused with any one issuer.

Vanguard Bond Index Fund. Vanguard Bond Index Fund—Total Bond Market Portfolio seeks a high level of interest income.

The fund attempts to match the performance of the Lehman Brothers Aggregate Bond Index, which is a widely recognized measure of the entire taxable U.S. Bond market. The index consists of more than 5,000 U.S. Treasury, federal agency, mortgage-backed, and high-quality corporate securities, with a total market value exceeding $4 trillion. Because it is not practical or cost-effective to own every security in the index, the fund invests in a large sample that matches key characteristics of the index (such as market-sector weightings, coupon interest rates, credit quality, and maturity). To boost returns, the fund holds a higher percentage than the index in high-quality, short-term corporate bonds and a lower percentage in short-term Treasury securities.

Vanguard Asset Allocation Fund. Vanguard Asset Allocation Fund seeks long-term growth of capital and income.

The fund invests in common stocks, long-term U.S. Treasury bonds, and money market instruments (cash reserves). The mix, or allocation, of the three types of assets changes from time to time depending on which mix appears to offer the best combination of expected returns and risk. Although the fund normally invests in two or more of the three asset types, it may at any time place all of its assets in one type—stocks, bonds, or cash reserves. To accomplish changes in allocations quickly and cost-effectively, the fund may use futures contracts instead of buying and selling individual securities.

Vanguard Index Trust-500 Portfolio. Vanguard Index Trust-500 Portfolio seeks long-term growth of capital and income from dividends.

The fund holds all of the 500 stocks that make up the Standard & Poor's 500 Composite Stock Price Index in proportion to their weighting in the index. The fund attempts to match the performance of the index, a widely recognized benchmark of U.S. stock market performance, and remains fully invested in stocks at all times. Its management does not speculate on the direction of the index. Though the fund seeks to match the index, its performance typically can be expected to fall short by a small percentage representing operating costs.

Vanguard Windsor II Fund. Vanguard/Windsor II seeks long-term growth of capital and income from dividends.

The fund invests in a diversified group of out-of-favor stocks of large-capitalization companies. It is managed by four advisers, each of whom runs its portion of the fund independently. The stocks they select are, as a group, selling at prices below the overall market average compared to their dividend income and future return potential.

Vanguard Morgan Growth Fund. Vanguard/Morgan growth Fund seeks long-term growth of capital.

The fund invests primarily in stocks of large and medium-sized companies that have strong records of growth in sales and earnings or that have performed well during certain market cycles. The fund also invests in stocks of smaller companies that offer good prospects for growth.

Vanguard PRIMECAP Fund. Vanguard/PRIMECAP Fund seeks long-term growth of capital.

The fund invests in stocks of companies with above-average prospects for continued earnings growth, strong industry positions, and skilled management teams. It also may invest in companies with below-average earnings but bright prospects for earnings growth. The fund may not be broadly diversified; at times the fund may invest a large portion of its assets in select industries.

Vanguard International Growth Portfolio. Vanguard International Growth Portfolio seeks long-term growth of capital. Participants in this fund do not own individual shares of Lockheed Martin stock.

The fund invests in stocks of high-quality, seasoned companies based outside the United States. It includes stocks with records of exceptional growth from more than 15 countries (including Japan, the United Kingdom, the Netherlands, Switzerland, and Germany).

The fund invests 60% to 70% of its assets in companies with sustainable competitive advantages and strong prospects for long-term growth. To supplement these core holdings and boost its allocations to particularly attractive markets, the fund also invests in large stocks in those markets that are expected to have particularly strong near-term returns.

Lockheed Martin Stock Fund (closed to new contributions). The Lockheed Martin Stock Fund seeks to provide long-term growth of capital

The fund invests in Lockheed Martin Corporation stock to provide investors the possibility of long-term growth through increases in the value of the stock and the reinvestment of its dividends. A small portion of the fund may also be invested in cash reserves—such as money market instruments—to help accommodate daily transactions.

Information about the risk associated with investment in these funds is available from Vanguard. Full prospectus information may be obtained by calling Vanguard at 1-800-523-1188.

Administrative Expenses

All external administrative expenses are funded from Plan assets and earnings.

ERISA 404(c) Qualification

The Plan is intended to allow you to control the investment of your accounts to the extent required to be an "ERISA 404(c) Plan." If an investment plan satisfies the requirements to be an "ERISA 404(c) Plan," its fiduciaries may be relieved of liability for any losses that are the direct and necessary result of participants' investment choices. Accordingly, neither the Company nor the Committee guarantees the performance of the Plan investment funds, and neither is liable for any losses you may experience due to investment performance.

Keep in mind that all investments carry some risk and there is a relationship between risk and reward. Neither the Company nor the Committee endorses any particular investment or investment mix, and no representative of the Company or of the Plan is authorized to advise you regarding investments. It is your responsibility to decide how your accounts should be invested. If you need help in making investment decisions, please consult your investment advisor.

Past Performance of Investment Funds

Information regarding the past performance of the various Investment Plan funds may be obtained by calling Vanguard at 1-800-523-1188. However, this past performance data should be used only for informational purposes. You should not rely on past performance to predict the future performance of any of the funds.

Investment Choices

You may direct the investment of your contributions to the funds in 1% increments. These investment choices will also apply to your share of the Company contributions.

If you do not designate how you want your contributions invested, the processing of your request will be delayed until Vanguard can determine which Plan funds you prefer.

Changing Your Investment Choices. You may change your investment choices for future contributions as frequently as every two weeks by calling Vanguard at 1-800-523-1188. You can use the automated telephone response system or speak with a Vanguard Associate. You can also make changes to your account by using Vanguard's website at www.Vanguard.com. Changes requested by 2:00 p.m. the Thursday before a payday will be effective with that payday.

Moving the Money in Your Account

You may move money between Plan funds by exchanging your account balances. Exchanges may be made on a daily basis either as a dollar amount or as a percentage of the account balance in the fund from which the exchange is made. Remember, however, that you may not make any exchange into the Lockheed Martin Stock Fund.

Movement of money between funds may be accomplished by calling Vanguard at 1-800-523-1188. You can use the automated telephone response system or speak with a Vanguard Associate. You can also make changes to your account by using Vanguard's web site at www.Vanguard.com. Exchanges requested by 2:00 p.m. (Idaho time) will be processed effective the end of the day requested. Exchanges requested after 2:00 p.m. (Idaho time) will be processed effective the end of the following day.

Proxy Voting

Except for the Lockheed Martin Stock Fund, the investment manager for each fund will decide how to exercise any voting rights appurtenant to stock held in that particular fund. With respect to the Lockheed Martin Stock Fund, you may direct the Plan Trustee how to vote a pro rata share of the Lockheed Martin Common Stock held in that fund corresponding to your interest in the fund.

Account Valuation and Statements

The value of your account will be computed on a daily basis and may be obtained by calling Vanguard at 1-800-523-1188. Each quarter, you will receive a written statement of the value of your account.

Investment fund values may be obtained at any time by calling Vanguard.

Vesting in Company Contributions

You are always vested in (i.e., you always own) the value of your own contributions to the Plan. Your right to Company contributions generally is based on your "cumulative years of service" with the Company. See *Definition of Cumulative Years of Service*. Your recognized service date for Investment Plan vesting is used to determine your years of service for the Plan.

The table below indicates when you will become vested in (or entitled to receive) your Company match money:

Cumulative Years of Service	Percentage of Company Match to Which You Are Entitled
Less than 2	0%
2 but less than 3	25%
3 but less than 4	50%
4 but less than 5	75%
5 or more	100%

In addition, you will automatically become 100% vested in the Company match (regardless of your years of service) if you are a Company employee on or after your 65th birthday or if you die or become permanently disabled while a Company employee. The full value of your contributions and your share of Company contributions is payable to your beneficiaries upon your death.

You will also automatically become 100% vested in the Company match if you retire under the terms of the current INEEL Employees Retirement Plan (or any subsequent qualified defined benefit Retirement Plan of the Company) or if you are laid off for at least four consecutive weeks as a result of a Company-initiated reduction in force that is designated in writing as a reduction in force that will result in such vesting.

Definition of Cumulative Years of Service. "Cumulative years of service" include all periods of service as a regular full-time employee, part-time employee or temporary employee with a Company that has adopted the Plan, subject to the Plan's break in service rules. See *Break in Service Rules*.

Your cumulative years of service are measured from your date of employment. If your employment terminates and you are rehired after at least a one-year period of severance, you will have a break in service and your cumulative service after reemployment will be measured from your adjusted reemployment date. If your employment terminates and you are rehired after less than a one-year period of severance, your cumulative service will be measured from your original employment date.

If your service for BBWI is immediately preceded or followed by service for a related entity and is the result of a direct transfer (e.g., there is no intervening termination of employment), you may also be eligible to receive cumulative service credit for the period of employment with the related entity.

Break in Service Rules. You will not earn cumulative service credit during any break in service. For purposes of the Plan, a "break in service" is any 12-month period, beginning on your severance date, in which you do not work at least one hour for the Company, or for a related entity following a direct transfer. Your severance date will be either:

The date you end employment with the Company or related entity

The first anniversary date of the commencement of any unpaid authorized leave of absence, as defined in the Plan document.

If You Are Rehired After a Break in Service. If you are partially or fully vested when you end employment and are later rehired, your cumulative years of service after your date of rehire will be added to your cumulative years of service before your date of rehire, regardless of the length of your break in service. Additionally, if your break in service is less than five years, any previously forfeited (nonvested) match money will be restored to your Company Matching Contributions Account.

Break in Service rules are technical and governed by provisions of the plan.

Plan Loans

As an alternative to making a withdrawal (See *Withdrawals*), you may take a loan from your Investment Plan account. Unlike a withdrawal, your loan proceeds will not have immediate income tax consequences. Additionally, borrowing from your Investment Plan account will not result in any suspension of the Company match on your regular contributions.

You may take a loan from your Investment Plan account for any reason. In contrast to the rules in effect for withdrawals (See *Withdrawals*), you do not have to experience a hardship situation to borrow from your pre-tax account. If your loan is used to buy your principal residence, your loan repayment period can be as long as 15 years. If your loan is used for any other purpose, it must be repaid within 5 years.

The amount you borrow will be taken proportionately from your pre-tax, after-tax, and rollover Plan accounts. Your proceeds will be reduced by a nominal set-up fee of $40. Repayment of principal and interest will be made in equal installments through automatic payroll deductions. The interest rate in effect at the time your loan is made will be fixed throughout the period of repayment. Both principal and interest payments are credited back to your account, in the same percentages used to allocate your loan proceeds. Loans are secured by your account under the Plan.

Limitations on Loan Amount. The amount you may borrow is subject to the following limitations:

You may borrow up to $50,000, reduced by your highest outstanding loan balance during the preceding 12 months.

The amount of your loan cannot exceed the total of your pre-tax, after-tax, and rollover account balances. You cannot borrow from your Company account (including Company match money and related earnings).

Your loan cannot be for an amount greater than 50% of the vested portion of your account.

The least you can borrow is $1,000.

You can only have one loan outstanding at a time from the Plan.

Applying for a Loan. You may apply for a loan by calling Vanguard at 1-800-523-1188 and speaking with a Vanguard Associate. (Alternatively, you may access your account via Vanguard's website at www.Vanguard.com.) Vanguard will calculate how much you can borrow and the amount of your monthly payments. When you have decided on the amount you wish to borrow, Vanguard will proceed with processing your loan.

If your loan will be used to purchase a primary residence, Vanguard will send you a loan application form to complete. You will not need to complete a loan application form if your Investment Plan loan proceeds will be used for other purposes.

After any required paperwork is completed and submitted to Vanguard, a check for the loan proceeds will be mailed to you at your home address. The amount you receive will be the approved loan amount less a nominal loan fee equal to $40.

After you have repaid one loan, you must wait at least 30 days before applying for another loan.

Annual Interest Rate. Once loan proceeds are distributed to you, you will be obligated to pay interest on your declining loan balance at the annual rate shown in your promissory note. The interest rate will remain constant throughout the period of repayment.

The formula used to calculate the interest due for a particular month is as follows:

$$\text{Interest} = \frac{(\text{Loan Balance at Start of Month}) \times (\text{Interest Rate})}{12}$$

The rate of interest applicable to Plan loans is subject to review and adjustment every calendar quarter and will be announced to all participants.

Repaying Your Loan. The payments of principal and interest on your Investment Plan loan will go directly back into your pre-tax, after-tax, and rollover accounts, in the same percentages used to allocate your original loan proceeds. A loan to buy a primary residence must be repaid in 15 years or less; a loan for any other reason must be repaid in five years or less.

Loan repayments will be made in equal installments through automatic after-tax payroll deductions. If you are not in pay status for any reason (including if you are approved for inactive employee status or short-term disability), you should plan to make cash payments for your loan installments to the Benefits Office. Failure to do so could result in loan default and taxation of the remaining unpaid loan balance, as explained below.

Prepayment. You can prepay a loan anytime after it has been in effect for three months. If your employment ends, you can repay the loan anytime within the 30-day period preceding your

termination date. In either case, the loan must be repaid in full in a lump sum. Partial prepayments are not allowed.

If your loan is not repaid in full prior to the termination of your employment, you will be subject to taxation on the remaining outstanding balance.

Loan Default. Your loan will be declared in default under the following circumstances:

You are an active employee with insufficient earnings to make a loan payment for 13 weeks (unless separate arrangements are made with the Benefits Office for direct payments).

You are 13 or more weeks behind in your loan payments for any reason. (Normally this will only apply to employees who are making their loan payments directly to the Benefits Office because of a situation that results in their not being in pay status.)

You file for bankruptcy under the U.S. Bankruptcy Code.

If you default on your loan, your regular contributions to the Plan will be suspended until one year from the date of default or the date you repay your outstanding loan balance in full (including any accrued interest), whichever is later. You will be ineligible to apply for a new loan until 30 days after you have made full repayment of the defaulted loan amount.

Plan Withdrawals

Subject to the following restrictions, you can make withdrawals from some of your accounts in the Plan.

Employees Who Are 100% Vested. If you are 100% vested in Company contributions, you may withdraw any portion of your funds in the Plan attributable to your after-tax contributions, any rollover contributions and any Company matching contributions. However, if you make more than two withdrawals during a plan year, the third withdrawal must be equal to your entire remaining balance in the Plan (including the Company's matching contributions), except for the amount attributable to your before-tax contributions.

Employees Who Are Not 100% Vested. If you are not 100% vested in Company contributions, once during a Plan year you may withdraw the entire portion of your Plan account that is attributable to your after-tax contributions and rollover contributions.

You may not withdraw any portion of your Company match money until you are fully vested, except in the event that your active employment terminates.

Financial Hardship. If you are under age 59 1/2 and (a) you suffer a financial hardship as defined in the Plan and that meets the requirements of Section 401(k) of the IRC, (b) you have already withdrawn your entire available vested funds in the Plan that are attributable to Company contributions and your after-tax contributions, and (c) you have used other ready cash reserves

(including funds available through the loan provisions of the Plan and personal resources), you may withdraw an amount that does not exceed the lesser of the following:

The value of your account that is attributable to your before-tax contributions or

The total amount you contributed to the Plan as before-tax contributions.

Under the IRC, a "financial hardship" includes eight specific conditions, as follows:

1. The down payment, closing costs, and other nonreimbursed expenses related to the construction, purchase or major renovation of the primary residence for the employee.

2. Payment of expenses to avoid foreclosure or eviction from a primary residence of the employee.

3. Medical expenses for an employee, or an employee's dependent, child, or spouse, that are not covered by a medical plan.

4. Tuition expenses, educational fees, books, and room and board expenses for the next 12 months of post-secondary education of an employee, or an employee's dependent, child, or spouse.

5. Uninsured expenses directly related to a natural disaster.

6. The need to replace lost wages (net of any other benefits received) due to an absence from the Company for a period of at least four consecutive weeks.

7. Expenses directly related to institutionalizing an employee, or a dependent, child or spouse of an employee. This does not include expenses for detention centers, jails or prisons.

8. Expenses for the funeral of an immediate family member of an employee. For this purpose, family member includes the participant's parent, spouse, or child (including an adopted child).

Suspension of Company Contributions. Following a withdrawal, Company contributions may stop for a period of time, as follows:

Type of Withdrawal	Length of Suspension of Company Contributions
Nonhardship withdrawal that does not exceed the employee's after-tax account and rollover account balance	3 Months
Nonhardship withdrawal in excess of	6 Months

the employee's after-tax account and rollover account balance	
Hardship withdrawal of before-tax account (before age 59 1/2)	No Suspension
Nonhardship withdrawal of before-tax account (after age 59 1/2)	No Suspension

The suspension period will generally begin with the paycheck following the date you receive the withdrawal proceeds.

Applying for a Withdrawal. To apply for a withdrawal, call Vanguard at 1-800-523-1188. Vanguard will advise you of the amount you have available for withdrawal and send you the appropriate withdrawal paperwork. Completed forms for nonhardship withdrawals may be submitted directly to Vanguard at P.O. Box 1101, Valley Forge, PA 19482. Completed forms for hardship withdrawals, together with appropriate documentation regarding the type of hardship and the amount required to satisfy same, should be submitted to the Benefits Office (MS 3200). The Benefits Office will consider hardship withdrawal applications on a case-by-case basis in accordance with the terms of the Investment Plan, and forward eligible applications to Vanguard for processing.

Vanguard will process your nonhardship or hardship withdrawal request and mail your withdrawal proceeds (net of applicable taxes) to your home address. Withdrawal values will be based on the value of your Plan account at the end of the day on which your request is processed. Pre-1987 after-tax contributions may be withdrawn without tax consequences. All other withdrawals will result in some tax consequences.

Funds that you withdraw from the Plan will be taken from your Plan accounts in the following priority:

1. Pre-1987 after-tax contributions

2. Other after-tax contributions and earnings

3. Rollover contributions and earnings

4. Vested Company contributions and earnings

5. Pre-tax contributions, subject to proving hardship if under age 59 1/2.

Depending upon the type of money withdrawn, the company match may be temporarily suspended following a withdrawal. The required period of suspension of Company contributions will generally be effective with the payday following the valuation date of your withdrawal. See *Plan Withdrawals: Suspension of Company Contributions*.

Taxation of Withdrawals and Distributions. The taxable part of your withdrawal or distribution will be subject to normal income taxes and a 10% early payment penalty (except that you may be exempt from the 10% penalty tax as discussed below). You will be subject to ordinary income tax on all taxable amounts. (See below for the tax rules on after-tax contributions.) You may be eligible for special five- or ten-year averaging, which may reduce your tax liability. Additional taxes may apply to large withdrawals or distributions.

Twenty percent of the taxable part of your withdrawal or distribution will generally be withheld automatically for federal income taxes at the time you receive your money. See Withholding Requirements for Withdrawals and Distributions.

Because everyone's financial situation is different and tax laws relating to retirement plans are complex, we urge you to seek professional tax advice concerning your Investment Plan withdrawal or distribution.

Taxation of After-Tax Contribution Withdrawals. Under current law, all of the after-tax contributions you made to the Investment Plan before January 1, 1987 (your "Pre-1987 Basis") may be withdrawn while you are an active employee without paying taxes on the money. If you make a withdrawal of after-tax contributions, your "Pre-1987 Basis" will automatically be withdrawn first.

Withdrawing after-tax contributions made after December 31, 1986 (your "Post-1986 Basis") will generate a tax liability because tax laws require that the distribution include a pro-rata portion of your investment earnings on all after-tax contributions. For these withdrawals, your tax liability will be based on the ratio of your remaining after-tax contributions to the total value of your after-tax account (i.e., contributions plus earnings). In many cases, as described below, the IRS will also impose a 10% early withdrawal penalty on the taxable portion of your distribution.

The 10% Early Payment Penalty Tax. When you withdraw money from your vested Investment Plan account balance, except for amounts you contributed as after-tax contributions, your withdrawal will be subject to income taxes. In addition, the IRS may require you to pay a 10% early payment penalty tax on the taxable part of your distribution. You will not be subject to this penalty if:

You are at least age 55 and receive your vested account balance because you terminated employment

You are at least age 59 1/2 when you receive the payment, whether or not you are actively employed

Your vested account balance is paid because of your disability or death

The withdrawal is used to pay unreimbursed medical expenses that exceed 7 1/2% of your adjusted gross income

The payment is made to someone else under a qualified domestic relations order

The distribution is rolled over to an Individual Retirement Account ("IRA") or another employer's qualified plan within 60 days. (Please note that proceeds from hardship withdrawals may not be directly rolled over to an IRA.)

Withholding Requirements for Withdrawals and Distributions. Federal income taxes equal to twenty percent will be withheld on almost any taxable balance you receive from the Investment Plan (in a direct payment to you, as opposed to a direct payment to an IRA or other qualified plan), even if you plan to roll over your withdrawal or distribution (which you may do within 60 days) and keep the money tax-sheltered for your retirement. This 20% withholding is intended to be a partial payment of the taxes you will owe on a taxable distribution. It does not include the additional 10% early distribution penalty tax you may be required to pay.

There are several situations where the mandatory 20% withholding does not apply, as follows:

If you elect a direct rollover of your withdrawal or distribution into an IRA or another employer's qualified plan (in this case the check will not be issued to you)

If the amount of your distribution is less than $200

If you are 70 1/2 or older and receive only the required minimum distribution from your account

If you receive your Plan balance after retirement in "substantially equal" installment payments over at least ten years

If payments are made to someone other than your spouse.

Following is an example of how these withholding rules work in a situation where you choose to roll over your taxable withdrawal proceeds but do not elect the direct rollover alternative:

> You terminate your employment and want a check issued in your name for your taxable Plan balance of $20,000. Taxes of $4,000 will be withheld and you will receive a check for $16,000.
>
> After receiving your check, you decide to roll the distribution proceeds over into your new employer's retirement Plan. To avoid having the withholding amount treated as a taxable distribution, you will have to come up with the $4,000 from your personal savings within 60 days and roll over that $4,000 with the $16,000 you receive from the Plan. You will then get a credit on your next income tax return for the $4,000 that was withheld.

Deferring Taxation of Plan Distributions (Rollovers). You may defer part or all of your taxes on the value of your before-tax contributions, vested matching contributions, rollover contributions and any investment earnings on these contributions, as well as on the earnings on your after-tax contributions by initiating a direct rollover of your vested account balance into another employer's plan or an IRA.

Summary of Plan Withdrawal Rules

The following table summarizes the Plan withdrawals you may make while actively employed, the Plan funds available, and the consequences of each type of withdrawal.

Type of Withdrawal	Plan Funds Available	Restrictions	Consequences
Non-Hardship Withdrawal, 100% Vested	All or part of: • After-tax contributions account • Rollover contributions account • Company matching contributions account	Two per Plan year	Matching contributions are suspended for three months if withdrawal includes only after-tax and rollover contribution accounts; the suspension period is six months if withdrawal includes company matching money. Mandatory 20% federal income tax withholding on taxable portion plus normal taxes. Early distribution penalty taxes (10%) may apply if not age 59 1/2 or older.
Third Non-Hardship Withdrawal Per Plan Year, 100% Vested	Total of: • After-tax contributions account • Rollover contributions account • Company matching contributions account	Restrictions apply after two prior non-hardship withdrawals (100% vested) in a Plan year.	Matching contributions are suspended for six months. Mandatory 20% federal income tax withholding on taxable portion plus normal taxes. Early distribution penalty taxes may apply if not age 59 1/2 or older.
Non-Hardship Withdrawal: Not 100% Vested	Total of: • After-tax contributions account and/or • Rollover contributions account	One per Plan year	Matching contributions are suspended for three months. Mandatory 20% federal income tax withholding on taxable portion plus normal taxes. Early distribution penalty taxes may apply if not age 59 1/2 or older.
Hardship Withdrawal	All or part of: • Before-tax contributions	Must demonstrate financial hardship. Must satisfy specific hardship reasons. Must first withdraw maximum amount from after-tax and matching contributions accounts. Must have loan from Investment Plan. Twice per Plan year.	No suspension of matching contributions. Mandatory 20% federal income tax withholding on taxable portion plus normal taxes. Early distribution penalty taxes may apply if not age 59 1/2 or older.

Other Distributions

Minimum Distributions at Age 70 1/2. The IRS requires that terminated Plan participants must begin taking distributions from their Investment Plan accounts at age 70 1/2. (Participants who are still employed with the Company at age 70 1/2 are not required to begin taking distributions from the Plan until their employment terminates.) You may have to pay a 50% excise tax if the minimum distribution requirements are not met. The Plan offers you the following options for receiving your money at age 70 1/2 (please note that the plan requires your first distribution to be received by December 31 of the year in which you reach age 70 1/2):

A lump-sum payment in cash, representing your entire account balance, or

Annual installment payments to be paid over four years. Under this alternative, you would receive 25% of your account the first year, 33 1/3% of the remaining balance the second year, 50% of the remaining balance the third year, and 100% the fourth year. At any time in this four-year period, you could elect to take the remaining balance in a lump-sum payment.

If you retire under the terms of the INEEL Employee Retirement Plan when your employment terminates, you may elect installment payments in fixed dollar or required minimum amounts, or over a fixed period. See *Installment Payments at Retirement Under the INEEL Retirement Plan*.

Contact Vanguard at 1-800-523-1188 for information on minimum distributions. If you are affected by these minimum distribution requirements, you will receive personalized information describing your options before you begin receiving payments. The Company cannot advise you on your personal finances; you should contact a tax adviser before making any decisions relating to your Plan distributions.

Transfer of Employment to an Affiliated Company. If your employment is transferred to an affiliated company, you will not be eligible to elect a distribution of your Plan funds until your employment with the affiliated company or other adopting company terminates.

If you are transferred to an affiliated company, you may participate the same as an active employee except that no additional contributions can be made. Thus, you will be eligible to make withdrawals during such continued employment at the affiliated company (subject to the same rules applicable to other participants) and will continue to direct the investment of your accounts. If you are not 100% vested when you are transferred (and your transfer is a direct transfer), you will receive cumulative years of service credit toward vesting for your employment with the affiliated company.

Payments When You Retire or End Employment Due to Termination, Disability, Layoff or Death. Your contributions and earnings and the vested portion of the Company matching contributions and earnings are payable as follows:

To you, when you retire or otherwise end employment with the Company and do not transfer to an affiliated company

To your beneficiary, if you die.

When you leave the Company (if you do not transfer to an affiliated company), you may elect an immediate lump-sum payment of your vested interest in your accounts (usually payable within 30 days of your employment termination date), or you may elect to leave your funds in the Plan until the age of 70 1/2. If you leave your funds in the Plan until age 70 1/2, you may choose between a lump-sum payment of your vested interest at age 70 1/2, or payment in four equal annual installments starting at 70 1/2, or payment in installments over a longer period (if you retired under the terms of the INEEL Employee Retirement Plan when your employment terminated).

The amount of the payment of your vested interest in your accounts will be based on the value of your accounts as of the end of the day on which your payment is made. If you leave your accounts in the Plan, you will continue to direct your investments and your accounts will be revalued in the normal manner until paid from the Plan.

You will forfeit (i.e., lose) any non-vested Company contributions when your funds are paid to you from the Plan or when you have a five-year break in service, whichever happens first. If you are rehired as an eligible employee before you have a five-year break in service, however, the forfeited amount will be restored to your account if you repay the withdrawn amount in a lump-sum payment within five years from the date you are rehired. Repayment will be made to your after-tax account.

Installment Payments at Retirement Under the INEEL Retirement Plan. If your employment with the Company terminates at or after age 55 due to retirement under the terms of the INEEL Retirement Plan and you have not transferred to an affiliated company, you may choose to receive payment of your account in either a single lump-sum payment, through partial withdrawals (limited to 2 per plan year) or in installment payments (subject to IRS minimum distribution rules affecting participants reaching age 70 1/2). You must begin to make withdrawals from your account (as specified above) after you reach age 70 1/2.

Retirees who are eligible for installment payments may elect payments in fixed dollar or required minimum amounts. Alternatively (subject to required minimum distribution rules), installment payments may be elected on a monthly, quarterly, semiannual or annual basis over any number of years. Additional information regarding installment options for retirees may be obtained by calling Vanguard at 1-800-523-1188.

Payments to a Beneficiary. If you die, the vested value of your account will be paid to your beneficiary(ies) in a lump-sum.

Plan Procedures and Deadlines

All Investment Plan transactions are processed by Vanguard. You can call Vanguard at 1-800-523-1188 to request any of the following transactions relative to your Investment Plan Account:

Initial Enrollment

Changes to your contribution amount (including contribution suspensions)

Changes to your contribution fund allocation

Exchanges between funds

Withdrawals

Loans.

You can use the automatic telephone response system or speak to a Vanguard Associate. You can also request some changes to your account by using Vanguard's website at www.Vanguard.com.

Account Balance Exchanges. You may request account balance exchanges on a daily basis. Account balance exchange requests made by 2:00 p.m. (Idaho time) will become effective the end of the day requested. Requests received after 2:00 p.m. (Idaho time) will be delayed a day.

Investment Contribution Changes. You may change the fund allocation and/or amount of your Plan contributions, or suspend your contributions, every pay period. Fund allocation changes requested by 2:00 p.m. (Idaho time) on the Thursday before a payday will be effective with that payday.

Contribution amount or suspension changes requested on or before the fifteenth of the month will be effective the first paycheck of the following month. Changes requested after the fifteenth of the month will be effective the second paycheck of the following month.

You will not be allowed to make retroactive contributions to compensate for contributions not made during a suspension period, or any other period, when you are not contributing to the Plan.

Plan Withdrawals. You may make two partial withdrawals each Plan year. Withdrawal requests are processed by Vanguard as they are received.

Plan Loans. Loan requests are processed by Vanguard as they are received.

Non-Alienation of Benefits and Qualified Domestic Relations Orders

The Plan specifically prohibits alienation or assignment, pledging or other similar use of any benefits, except that the Plan must obey Qualified Domestic Relations Orders ("QDROs") issued by a court requiring benefit payments to a spouse, former spouse, child or other dependents. These court orders must comply with the requirements of the IRC and be approved by the Plan Administrator before any payments are made.

Plan Expenses

Brokerage commissions and related expenses are payable out of the assets of the investment fund to which they relate unless stated otherwise. The Plan also provides that all other plan operation and administration expenses, including the compensation of the Plan Trustee, investment managers, and administrative service providers, may be paid out of the assets of the Plan.

Top-Heavy Provisions

A retirement plan that primarily benefits certain owners or officers of the employer is called a top-heavy plan. A plan is considered top heavy when more than 60% of the Plan's assets benefit those employees.

The Plan is not top heavy at this time. If it were to become top heavy in any Plan year, all other employees would be entitled to certain minimum benefits, and other special plan provisions could apply. Should the Plan become top heavy, the Plan Administrator will notify you of your rights.

Tax Treatment to the Company

The Company intends to operate the Plan so that it will qualify under Section 401(a) of the IRC. Accordingly, before-tax contributions and Company contributions will be deductible by the Company for income tax purposes and the earnings of the Trust that holds the Plan assets will not be taxable to the Trust or the Company.